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Lieutenant Governor

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Deputy Director
Health Care Financing
Michael T. Hales
Acting Division Director

DATE: February 10, 2006 LTCB-003-06

TO: Medicaid 1915(c) HCBS PD Waiver Network

FROM: Tonya Keller, Director
Bureau of Long Term Care

SUBJECT: Draft Renewal Application for Public Comment – HCBS Waiver for Individuals With Physical Disabilities

The Division of Health Care Financing, in cooperation with the Division of Services for People with Disabilities, invites you to review and provide comments on the Draft Renewal Application for the **Medicaid Home and Community-Based Waiver for Individuals with Physical (PD Waiver).**

The current waiver 5-year authorization period expires June 30, 2006 and the State desires to renew the waiver for another five years. A renewal application must be submitted to the Centers for Medicaid and Medicaid Services (CMS) on or before March 31, 2006. Over the last three months an eight member work group representing the Division of Health Care Financing, the Division of Services for People with Disabilities, waiver providers and waiver consumer advocates developed an initial draft in preparation for public comment.

The draft renewal application is available in electronic format. You may obtain the draft application for review by contacting:

Kim Rognon-Sato		John Strong
(801) 538-6653	or	(801) 538-6587
kimrognonsato@utah.gov		jlstrong@utah.gov

Written Comments will be accepted until close of business on March 1, 2006. Please send all comments to:

Utah Department of Health
ATTN: Tonya Keller
PO Box 143101
Salt Lake City UT 84114-3101 or kimrognonsato@utah.gov

Utah Department of Health
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Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare. It also stresses the importance of respecting the preferences and autonomy of waiver participants. The Framework identifies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy that promotes the achievement of the desired outcomes expressed in the Quality Framework.

HCBS Quality Framework

Focus	Desired Outcome
Participant Access	*Individuals have access to home and community-based services and supports in their communities.*
Participant-Centered Service Planning and Delivery	*Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*
Provider Capacity and Capabilities	*There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
Participant Safeguards	*Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
Participant Rights and Responsibilities	*Participants receive support to exercise their rights and in accepting personal responsibilities.*
Participant Outcomes and Satisfaction	*Participants are satisfied with their services and achieve desired outcomes.*
System Performance	*The system supports participants efficiently and effectively and constantly strives to improve quality.*

I. Request Information

A. The **State** of **Utah** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional*): Physical Disabilities Waiver

C. Type of Request *(select only one)*:

○	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
○	**New Waiver (3 Years) to Replace Waiver #**		
	CMS-Assigned Waiver Number (*CMS Use*):		
	Attachment #1 contains the transition plan to the new waiver.		
✓	**Renewal (5 Years) of Waiver #**	0331.01	

D. Type of Waiver *(select only one)*:

○	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
✓	**Regular Waiver,** as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: July 1, 2006

E.2 Approved Effective Date *(CMS Use):*

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan *(check each that applies)*:

☐	Hospital *(select applicable level of care)*	
	○	Hospital as defined in 42 CFR §440.10
	○	Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160
✓	Nursing Facility *(select applicable level of care)*	
	✓	As defined in 42 CFR §440.40 and 42 CFR §440.155
	○	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☐	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)	

G. Level(s) of Care Subcategories. Specify whether the State additionally limits the waiver to subcategories of the level(s) of care specified in Item I-F *(select one)*:

○	The waiver is available only to individuals under the following Medicaid State plan subcategories of the level(s) of care specified in Item I-F *(specify)*:
✓	Not applicable

H. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities *(check the applicable authority or authorities)*:

<table>
<tr><td>☐</td><td colspan="4">Services furnished under the provisions of §1915(a) of the Act and described in Appendix I</td></tr>
<tr><td rowspan="2">☐</td><td colspan="4">Waiver(s) authorized under §1915(b) of the Act. Specify the program:</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td rowspan="3"></td><td colspan="4">Specify the §1915(b) authorities under which this program operates (check each that applies):</td></tr>
<tr><td>☐</td><td>§1915(b)(1) (mandated enrollment to managed care)</td><td>☐</td><td>§1915(b)(3) (employ cost savings to furnish additional services)</td></tr>
<tr><td>☐</td><td>§1915(b)(2) (central broker)</td><td>☐</td><td>§1915(b)(4) (limit number of providers)</td></tr>
<tr><td>☐</td><td colspan="4">A program authorized under §1115 of the Act. Specify the program:</td></tr>
<tr><td></td><td colspan="4"></td></tr>
<tr><td>✓</td><td colspan="4">Not applicable</td></tr>
</table>

II. Brief Program Description

Brief Program Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

This waiver provides services and supports for people with significant physical disabilities living in the community. It is designed to be consistent with a service delivery system that promotes and supports participant self determination, maintains a high standard of quality in services and supports and maximizes the distribution and utilization of public funds, both state and federal. The State Medicaid Agency (SMA) has entered into an interagency agreement for the day-to-day administration and operation of this waiver with the State Department of Human Services, Division of People with Disabilities. The SMA retains final administrative authority over the waiver program.

III. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item E must be completed.*

A. Waiver Administration and Operation. **Appendix A** specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. **Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. **Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

✓	The waiver provides for participant direction of services. *Appendix E is required.*
○	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not included.*

F. Participant Rights. **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Management Strategy. **Appendix H** contains the Quality Management Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

IV. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in item I.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

✓	Yes
○	No
○	Not applicable

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

○	**Yes** *(complete remainder of item)*
✓	**No**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. S*pecify the areas to which this waiver applies*:
☐	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make participant-direction of services as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive the same services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver*:

V. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation are specified in **Appendix B**.

D. Choice of Alternatives: When an individual is determined to be likely to require the level of care specified for this waiver and is in the target group(s) specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: Absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

VI. Additional Requirements

Note: Item I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider who furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to specific waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b)(4) or another section of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431, Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing.

H. Quality Management. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications (d); participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

The Division of Health Care Financing, the State Medicaid Agency (SMA) in collaboration with the division of Services for People with Disabilities, the waiver operating agency, convened a workgroup consisting of current waiver participants, advocates, the Department of Health's Indian Health Liaison, and State stakeholders. The workgroup meetings began in late November 2005 and were open to the public. The workgroup provided the public with the opportunity to give feedback and engage in discussions with the SMA about the proposed waiver renewal application. The workgroup participated in a series of meetings through mid-January.

During the month of February, the draft waiver renewal application was disseminated for broad public input. Public input on the waiver application was compiled for review by the State Medicaid Director for his consideration.

During the development of the waiver renewal application, the SMA met with the Utah Indian Health Advisory Board beginning in December 2005 to describe and seek input into the renewal process and to provide ongoing status reports and consultation throughout the renewal process.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments maintaining a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS to at least 60 days before the anticipated submission date per Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficiency Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficiency persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficiency persons.

VII. Contact Person(s)

A. The State Medicaid Agency representative with whom CMS should communicate regarding the waiver is:

Name:	Tonya Keller
Title:	Director Bureau Long Term Care
Agency:	Utah Department of Health, Division of Health Care Financing
Address:	288 N 1460 W PO Box 143101 SLC, UT 84114-3101
Telephone:	(801) 538-9136
E-mail	tkeller@utah.gov

B. If applicable, the State Operating Agency representative with whom CMS should communicate regarding the waiver is:

Name:	George Kelner
Title:	Director
Agency:	Division of People with Disabilities
Address:	120 N 200 W #411 SLC, UT 84103
Telephone:	(801) 538-4208
E-mail	GKELNER@utah.gov

VIII. Authorizing Signature

This document, together with Appendices A through J and any attachments, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form when requested by CMS through the Medicaid Agency or, if applicable, from the waiver operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted in writing by the State Medicaid Agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the waiver and will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the request.

Signature: _____
State Medicaid Director or Designee

Print Name:	Michael Hales
Title:	Acting Director
Agency:	Division of Health Care Financing
Telephone:	801-538-6965
E-mail	mthales@utah.gov
Date	February 10, 2006

Attachment #1: Transition Plan to New Waiver

Note: Attachment #1 is completed only when a state proposes a new waiver to replace an existing waiver program.

Specify the transition plan from the current waiver to the new replacement waiver:

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver *(select one)*:

○	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):		
	○		, the Medical Assistance Unit.
	○		, another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit. *Do not complete item A-2.*
✓	The waiver is operated by **Division of Services for People with Disabilities (DSPD)** a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency. *Complete item A-2.*		

2. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements:

INTERAGENCY AGREEMENT FOR OPERATIONS AND ADMINISTRATION OF THE HCBS WAIVER

An interagency agreement between the State Medicaid Agency and DSPD sets forth the respective responsibilities for the administration and operation of this waiver. The agreement delineates the State Medicaid Agency's overall responsibility to provide management and oversight of the waiver including review and approval of all waiver related rules and policies to ensure compliance with Medicaid HCBS Waiver rules and regulations. The agreement also delineates DSPD's roles in relation to the statutory responsibilities to develop the State's program for persons with disabilities. The nature of the agreement enhances provider access to the Medicaid program and quality assurance of services as well as defines the fiscal relationship between the two agencies.

The major components of the agreement are:

1. Purpose and Scope;
2. Authority;
3. Definitions;
4. Waiver Program Administration and Operation Responsibilities;
5. Claims Processing;
6. Payment for Delegated Administrative Duties (including provisions for

State match transfer);
7. Role Accountability and FFP Disallowances; and
8. Coordination of DHS Policy Development as it Relates to Implementation of the Medicaid Program.

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency or the waiver operating agency (if different than the Medicaid agency) (s*elect one)*:

○	Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or waiver operating agency.
✓	Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency.

4. **Role of Local/Regional Non-State Entities**. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and specify the type of entity *(check each that applies)*:

☐	**Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency. *Specify the nature of these agencies and complete items A-5 and A-6:*
☐	**Local/regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. The **contract(s)** under which private entities conduct waiver operational functions are available through the Medicaid agency. *Specify the nature of these entities and complete items A-5 and A-6*:
✓	**Not applicable** – All waiver operational and administrative functions are performed by a state agency. *Do not complete items A-5 and A-6.*

5. **Responsibility for Assessment of Performance of Local/Regional Non-State Entities.** Specify the State agency that is responsible for assessing the performance of non-state entities that conduct waiver operational and administrative functions and the frequency of conducting such assessments:

6. **Assessment Methods.** Describe the methods that the State uses to assess the performance of non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements:

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and indicate the age range of individuals served in each subgroup.*

Included	Target Group/Subgroup	AGE RANGE (THROUGH 21)		AGE RANGE (22 THROUGH 64)		AGE RANGE (65 AND OLDER)
		From	To	From	To	
○	**Aged or Disabled, or Both**					
☐	Aged					☐
✓	Disabled (Physical)			18	No Limit	☐
☐	Disabled (Other)					☐
	Specific Aged/Disabled Subgroups					
☐	Brain Injury					☐
☐	HIV/AIDS					☐
☐	Medically Fragile					☐
☐	Technology Dependent					☐
○	**Mental Retardation or Developmental Disability, or Both**					
☐	Autism					☐
☐	Developmental Disability					☐
☐	Mental Retardation					☐
○	**Mental Illness**					
☐	Mental Illness					☐
☐	Serious Emotional Disturbance					

b. Additional Criteria. The State further specifies its target group(s) as follows:

The individual must:

1. Have established eligibility through the Utah Department of Human Services for state matching funds in accordance with UCA 62A-5.
2. Meet admission criteria for Nursing Facility (NF) care in accordance with UAC 414-502-3.
3. Have at least one personal attendant trained (or willing to be trained) and available to provide the authorized waiver services in a residence that is safe and can accommodate the personnel and equipment (if any) needed to adequately and safely care for the individual.
4. Be medically stable, have a physical disability and require in accordance with his/her physician's written documentation, at least 14 hours per week of personal assistance services (as described in appendix B of this waiver) in order to remain in the community and prevent unwanted institutionalization. For purposes of this waiver, the individual's qualifying disability and need for personal assistance services are attested to by a medically determinable physical impairment which the physician will expect to last for a continuous period of not less than 12 months and which has resulted in the individual's functional loss of two or more limbs, to the extent that the assistance of another trained person(s) is required in order to accomplish activities of daily living/instrumental activities of daily living.

5. Have decision making capability, as certified by his/her physician, of selecting, training and supervising her/his own attendant(s).*
6. Have decision making capability of managing the individual's own financial and legal affairs.

* Individual's possessing decision making capability, but having communication deficits or limited English proficiency may select a representative to communicate decisions on the individual's behalf.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limitation on individuals who may be served in the waiver, describe the transition planning procedures for participants affected by the age limit *(select one)*:

✓	Not applicable – There is no maximum age limit
○	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*):

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or enrollment in the waiver to an otherwise eligible individual *(select one)*:

- ✓ **No Cost Limit**. The State does not apply an individual cost limit. *Do not complete item B-2-b or item B-2-c*.
- ○ **Cost Limit in Excess of Institutional Costs.** The State refuses enrollment in the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver by an amount specified by the State. *Complete items B-2-b and B-2-c*. The limit specified by the State is *(select one)*:
  - ○ _____ %, a level higher than 100% of the institutional average
  - ○ Other *(specify)*:
- ○ **Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses enrollment in the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the 100% of the cost of the level of care specified for the waiver. *Complete items B-2-b and B-2-c*.
- ○ **Cost Limit Lower Than Institutional Costs**. The State refuses enrollment in the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis for this limit*:

  Complete items B-2-b and B-2-c. The cost limit specified by the State is *(select one)*:
  - ○ The following dollar amount: $ _____
    The dollar amount *(select one)*:
    - ○ Is adjusted each year that the waiver is in effect by applying the following formula:
    - ○ May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
  - ○ The following percentage that is less than 100% of the institutional average: _____ %
  - ○ Other – *Specify:*

b. Method of Implementation of Cost Limit. When an individual cost limit as specified in item B-2-a is employed, specify the procedures that are followed to determine before waiver enrollment that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in item B-2-a and there is a change in the participant's condition or circumstances that requires the provision of services in excess of the cost limit in order to assure the participant's health and welfare, the State provides for the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

☐	The participant is referred for enrollment to another waiver that can accommodate the individual's needs.
☐	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
☐	Other safeguard(s) *(specify)*:

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or other reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	Currently set at 135
Year 2	135
Year 3	135
Year 4 (renewal only)	135
Year 5 (renewal only)	135

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Select whether the State limits the number of participants in this way: *(select one)*:

✓	The State does not limit the number of participants that it serves at any point in time during a waiver year.
○	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

c. Reserved Waiver Participant Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or offering waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

✓	Does not reserve capacity.
○	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

✓	The waiver is not subject to a phase-in or a phase-out schedule.
○	The waiver is subject to a phase-in or phase-out schedule that is included in Appendix J and which constitutes an ***intra-year*** limitation on the number of participants who are served in the waiver.

e. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

A. Medicaid recipients who meet the eligibility requirements of the Physical Disabilities Waiver may choose to receive services in a NF or through the Physical Disabilities Waiver if available capacity exists, to address health, welfare, and safety needs.

B. If no available capacity exists in the Physical Disabilities Waiver, the applicant will be advised in writing that he or she may access services through a NF or may wait for open capacity to develop in the Physical Disabilities Waiver. To determine the ranking of waiting list applicants, a Critical Needs Assessment is completed. The applicant scores are then ranked with the most critical first.

C. If available capacity exists in the Physical Disabilities Waiver, a pre-enrollment screen of health, welfare, and safety needs will be completed by the Administrative Case Management Agency. The applicant will be advised of the preliminary needs identified and given the opportunity to choose to

receive services to meet the identified needs through a NF or the Physical Disabilities Waiver. The applicant's choice will be documented in writing, signed by the applicant, and maintained as part of the individual record.

The State has developed policies prioritizing access to individuals waiting for waiver services. These policies provide opportunities for access to individuals residing in the community and in institutional settings.

The DSPD has established a Critical Needs Assessment process by which individuals are ranked to prioritize access to waiver services. A significant component of the Critical Needs Assessment tool addresses the immediacy of the need for services and the individual's risk in not gaining access to waiver services.

Individuals in nursing facilities do not demonstrate an immediate need for services, nor do they present as being at high risk if waiver services are not extended to them, individuals in institutional facilities rank extremely low on the prioritization for receipt of waiver services. The State recognized this problem and initiated a separate process in which individuals in institutional settings may gain access to waiver services. Medicaid recipients residing in nursing facilities, meeting the Physical Disabilities Waiver criteria may gain access to the waiver by having the State general funds that supported the person in the nursing facility follow the person into the Physical Disabilities waiver, the money-follow-the-person concept. The State believes the existence of these two access points of admission into the waiver is an equitable methodology to support access from both the institution and the community.

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. State Classification. The State is a *(select one)*:

○	§1634 State
✓	SSI Criteria State
○	209(b) State

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

☐	Low income families with children as provided in §1931 of the Act			
✓	SSI recipients			
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121			
✓	Optional State supplement recipients			
✓	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*			
	✓	100% of the Federal poverty level (FPL)		
	○	%	of FPL, which is lower than 100% of FPL	
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)			
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)			
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)			
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 group as provided in §1902(e)(3) of the Act)			
✓	Medically needy (42 CFR §435.320, §435.322, §435.324 and §435.330)			
☐	Other specified groups (include only statutory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			
Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed				
☐	All individuals in the special home and community-based waiver group under 42 CFR 435.217			
✓	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:			
	✓	A special income level equal to (select one):		
		✓	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of FBR, which is lower than 300% (42 CFR §435.236)
		○	$	which is lower than 300%
	☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)		

	✓	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)		
	☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)		
	☐	Aged and disabled individuals who have income at: *(select one)*		
		○	100% of FPL	
		○	%	of FPL, which is lower than 100%
	☐	Other specified groups (include only statutory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:		

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. SSI states must complete Item B-5-b; Section 209(b) states must complete Item B-5-c. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one)*:

✓	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):
	○ Use *spousal* post-eligibility rules under §1924 of the Act. *Complete Item B-5-d*.
	✓ Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State) (*Complete Item B-5-b*) or §435.735 (209b State) (*Complete Item B-5-c*)
○	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.

b. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
✓	The following standard included under the State plan *(select one)*			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	✓	The special income level for institutionalized persons *(select one):*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300%.
	○		%	of the Federal poverty level
	○	Other (specify):		
○	The following dollar amount:	$		If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:			

ii. Allowance for the spouse only (*select one*):			
○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
✓	Not applicable *(see instructions)*		
iii. Allowance for the family *(select one)*:			
○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Other (specify):		
✓	Not applicable (see instructions)		
iv. The State also will deduct medical and remedial care expenses specified in 42 CFR §435.726.			

c. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ The following standard under 42 CFR §435.121:
    - [ ]
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one)*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ [ ] % of the FBR, which is less than 300%
    - ○ $ [ ] which is less than 300% of the FBR
  - ○ [ ] % of the Federal poverty level
  - ○ Other (specify):
    - [ ]
- ○ The following dollar amount: $ [ ] If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:
  - [ ]

ii. Allowance for the spouse only (*select one*):

- ○ The following standard under 42 CFR §435.121
  - [ ]
- ○ Optional State supplement standard
- ○ Medically needy income standard
- ○ The following dollar amount: $ [ ] If this amount changes, this item will be revised.
- ○ The amount is determined using the following formula:
  - [ ]
- ○ Not applicable *(see instructions)*

iii. Allowance for the family *(select one)*

- ○ AFDC need standard
- ○ Medically needy income standard

○	The following dollar amount: $ ____ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable (see instructions)

iv. The State also will deduct medical and remedial care expenses specified in 42 CFR §435.735.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State plan.

i. <u>Allowance for the personal needs of the waiver participant</u> *(select one)***:**			
○	SSI Standard		
○	Optional State Supplement standard		
○	Medically Needy Income Standard		
○	The special income level for institutionalized persons		
○	____ %	of the Federal Poverty Level	
○	The following dollar amount:	$ ____	If this amount changes, this item will be revised
○	The following formula is used to determine the needs allowance:		
○	Other (*specify*)**:**		

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Appendix B-6: Evaluation/Reevaluation of Level of Care

a. Evaluation of Level of Care. As provided in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future, but for the availability of home and community-based waiver services.

b. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services: (a) the individual must require the provision of at least One (*insert number*) service(s) offered under the waiver; and, (b) the individual must require the provision of waiver services at least monthly or, if less frequently, require regular monthly monitoring as documented in the service plan.

c. Fair Hearing. As specified in Appendix F, the State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals who are determined not to meet the level of care requirements for this waiver.

d. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

○	Directly by the Medicaid agency
✓	By the operating agency specified in Appendix A
○	By an entity under contract with the Medicaid agency. *Specify the entity*:
○	Other (*specify*):

e. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Individuals performing initial level of care evaluations will be Utah licensed registered nurses employed by the operating agency.

f. Process for Level of Care Evaluation/Reevalaution. Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Utah State administrative rule R414-502 delineates the nursing facility level of care criteria that must be met to qualify for Medicaid reimbursement under the State Plan nursing facility benefit. In accordance with R414-502, in determining whether an applicant has mental or physical conditions that can only be cared for in a nursing facility, or equivalent alternative Medicaid health care delivery programs, must document that at least two of the following factors exist:

a) Due to diagnosed medical conditions, the applicant requires substantial physical maintenance with activities of daily living above the level of verbal prompting, supervision, or setting up;

b) The attending physician has determined that the applicant's level of dysfunction in orientation to person, place or time requires nursing facility care; or equivalent care provided through an

alternative Medicaid health delivery program; or

c) The medical condition and intensity of services indicate that the care needs of the applicant cannot be safely met in a less structured setting; or without the services and supports of an alternative Medicaid health care delivery program.

The Operating Agency will provide for an evaluation (and periodic reevaluations) of the need for the level of care specified in item 1-F of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services. The State Operating Agency utilizes the following process to make level of care determinations as follows:

The registered nurse employed by the Operating Agency will conduct a level of care assessment using the standard waiver instrument described in Appendix B-6(g).

g. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), Attachment #1 to Appendix B-6 contains a copy of the instrument(s) used in the initial evaluation and reevaluation of an individual's need for the level of care in this waiver. Indicate whether the instrument(s) differs from the form used to evaluate institutional level of care *(select one)*:

○	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
✓	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.
	The InterRAI MINIMUM DATA SET- HOME CARE (MDS-HC) serves as the standard comprehensive assessment instrument for this waiver and includes all the data fields necessary to measure the individual's level of care as defined in the State Medicaid nursing facility admission criteria. Persons responsible for collecting the needed information and for making the initial level of care determination are trained by staff of the administering agency in the proper application of the MDS-HC instrument and the proper analysis of the MDS-HC data to evaluate level of care eligibility.

h. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

○	Every three months
○	Every six months
○	Every twelve months
✓	Other schedule (*specify*):
	A full level of care reevaluation is conducted at a minimum within 12 consecutive months of the last recorded full level of care evaluation, or more frequently, whenever indicated by a significant change in the individual's health status. The individual's level of care is screened at the time a substantial change in the individual's health status occurs, including at the conclusion of an inpatient stay in a medical institution, to determine whether the individual's resultant health status constitutes an ongoing nursing facility level of care.

i. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

✓	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
○	The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*:

j. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

The Operating Agency will maintain a tracking system as part of the overall management of eligibility determination and enrollment functions to assure compliance with the provisions of Appendix B-6.

k. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records of level of care evaluations and reevaluations will be maintained in the individual's waiver case record maintained by the Operating Agency.

The State Medicaid Agency retains the final authority for oversight of the level of care evaluation process. The oversight function involves an annual review of the level of care evaluations for a sample of waiver participants representative of the caseload distribution across the program. In the event the sampling identifies potential systemic problems with level of care evaluations, an expanded review would be initiated by the State Medicaid Agency.

Appendix B-7: Freedom of Choice

a. Freedom of Choice. When an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

b. Fair Hearing. As specified in Appendix F, the State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, subpart E, to individuals who are not informed of any feasible alternatives under the waiver or given the choice of home or community-based waiver services.

c. Procedures. Per 42 CFR §441.303(d), specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services.

The administrative case manager is responsible for assisting the applicant in completing the eligibility determination and enrollment process. Once it appears the applicant will likely meet nursing home level of care and generally assesses the individual's LTC needs, the applicant is provided information about the types of services available through the waiver and through the Medicaid nursing home program as part of the pre-enrollment education process.

When the administrative case manager has determined the individual can be adequately served in the community, the individual is informed of any feasible alternatives under the waiver and given the choice of either institutional or home and community based services.

The individual is informed that the SMA provides an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals who are not given the choice of receiving services in a home or community-based setting or receiving services in a nursing facility.

d. Freedom of Choice Documentation. Attachment #1 to Appendix B-7 contains a copy of the form used to document freedom of choice.

e. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Freedom of Choice documents are maintained in the individual's case record maintained by the Operating Agency.

Appendix B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficiency Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficiency persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Medicaid providers are required to provide foreign language interpreters for Medicaid clients who have limited English proficiency. Clients are entitled to an interpreter to assist in making appointments for qualified procedures and during those visits. Providers must notify clients that interpretive services are available at no charge. The SMA encourages clients to use professional services rather than relying on a family member or friend though the final choice is theirs. Using an interpretive service provider ensures confidentiality as well as the quality of language translation.

Attachment #1 to Appendix B-6

MINIMUM DATA SET - HOME CARE (MDS-HC)©

• Unless otherwise noted, score for last 3 days

• Examples of exceptions include IADLs/Continence/Services/Treatments where status scored over last 7 days

SECTION AA. NAME AND IDENTIFICATION NUMBERS

1.	NAME OF CLIENT	a. (Last/Family Name) b. (First Name) c. (Middle Initial)
2.	CASE RECORD NO.	
3.	GOVERNMENT PENSION AND HEALTH INSURANCE NUMBERS	a. Pension (Social Security) Number b. Health insurance number (or other comparable insurance number)

SECTION BB. PERSONAL ITEMS *(Complete at Intake Only)*

1.	GENDER	1. Male 2. Female
2.	BIRTHDATE	Month Day Year
3.	RACE/ ETHNICITY ©	*(Check all that apply)* *RACE* American Indian/Alaskan Native Asian Black or African American Native Hawaiian or other Pacific Islander White *ETHNICITY:* Hispanic or Latino
4.	MARITAL STATUS	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced 6. Other
5.	LANGUAGE ©	Primary Language 0. English 1. Spanish 2. French 3. Other
6.	EDUCATION *(Highest Level Completed)*	1. No schooling 2. 8th grade/less 3. 9-11 grades 4. High school 5. Technical or trade school 6. Some college 7. Bachelor's degree 8. Graduate degree
7.	RESPONSIBILITY/ ADVANCE DIRECTIVES	*(Code for responsibility/advance directives)* 0. No 1. Yes a. Client has a legal guardian b. Client has advance medical directives in place (for example, a do not hospitalize order)

SECTION CC. REFERRAL ITEMS *(Complete at Intake Only)*

1.	DATE CASE OPENED/ REOPENED	Month Day Year
2.	REASON FOR REFERRAL	1. Post hospital care 2. Community chronic care 3. Home placement screen 4. Eligibility for home care 5. Day care 6. Other
3.	GOALS OF CARE	*(Code for client/family understanding of goals of care)* 0. No 1. Yes a. Skilled nursing treatments b. Monitoring to avoid clinical complications c. Rehabilitation d. Client/family education e. Family respite f. Palliative care
4.	TIME SINCE LAST HOSPITAL STAY	Time since discharge from last in-patient setting (*Code for most recent instance in LAST 180 DAYS*) 0. No hospitalization within 180 days 1. Within last week 2. Within 8 to 14 days 3. Within 15 to 30 days 4. More than 30 days ago
5.	WHERE LIVED AT TIME OF REFERRAL	1. Private home/apt. with no home care services 2. Private home/apt. with home care services 3. Board and care/assisted living/group home 4. Nursing home 5. Other
6.	WHO LIVED WITH AT REFERRAL	1. Lived alone 2. Lived with spouse only 3. Lived with spouse and other(s) 4. Lived with child (not spouse) 5. Lived with other(s) (not spouse or children) 6. Lived in group setting with non-relative(s)
7.	PRIOR NH PLACEMENT	Resided in a nursing home at anytime during **5 YEARS** prior to case opening 0. No 1. Yes
8.	RESIDENTIAL HISTORY	Moved to current residence within last two years 0. No 1. Yes

SECTION A. ASSESSMENT INFORMATION

1.	ASSESSMENT REFERENCE DATE	*Date of assessment* Month Day Year
2.	REASONS FOR ASSESSMENT	*Type of assessment* 1. Initial assessment 2. Follow-up assessment 3. Routine assessment at fixed intervals 4. Review within 30-day period prior to discharge from the program 5. Review at return from hospital 6. Change in status 7. Other

SECTION B. COGNITIVE PATTERNS

1.	MEMORY RECALL ABILITY	*(Code for recall of what was learned or known)* 0. Memory OK 1. Memory problem a. Short-term memory OK — seems/appears to recall after 5 minutes b. Procedural memory OK—Can perform all or almost all steps in a multitask sequence without cues for initiation
2.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	a. How well client made decisions about organizing the day (e.g., when to get up or have meals, which clothes to wear or activities to do) 0. *INDEPENDENT*—Decisions consistent/reasonable/safe 1. *MODIFIED INDEPENDENCE*—Some difficulty in new situations only 2. *MINIMALLY IMPAIRED*—In specific situations, decisions become poor or unsafe and cues/supervision necessary at those times 3. *MODERATELY IMPAIRED*—Decisions consistently poor or unsafe, cues/supervision required at all times 4. *SEVERELY IMPAIRED*—Never/rarely made decisions b. Worsening of decision making as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) 0. No 1. Yes
3.	INDICATORS OF DELIRIUM	a. Sudden or new onset/change in mental function over **LAST 7 DAYS** (including ability to pay attention, awareness of surroundings, being coherent, unpredictable variation over course of day) 0. No 1. Yes b. In the **LAST 90 DAYS** (or since last assessment if less than 90 days), client has become agitated or disoriented such that his or her safety is endangered or client requires protection by others 0. No 1. Yes

SECTION C. COMMUNICATION/HEARING PATTERNS

1.	HEARING	*(With hearing appliance if used)* 0. *HEARS ADEQUATELY*—Normal talk, TV, phone, doorbell 1. *MINIMAL DIFFICULTY*—When not in quiet setting 2. *HEARS IN SPECIAL SITUATIONS ONLY*—Speaker has to adjust tonal quality and speak distinctly 3. *HIGHLY IMPAIRED*—Absence of useful hearing
2.	MAKING SELF UNDERSTOOD (Expression)	*(Expressing information content—however able)* 0. *UNDERSTOOD*—Expresses ideas without difficulty 1. *USUALLY UNDERSTOOD*—Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required 2. *OFTEN UNDERSTOOD*—Difficulty finding words or finishing thoughts, prompting usually required 3. *SOMETIMES UNDERSTOOD*—Ability is limited to making concrete requests 4. *RARELY/NEVER UNDERSTOOD*
3.	ABILITY TO UNDERSTAND OTHERS (Comprehension)	*(Understands verbal information—however able)* 0. *UNDERSTANDS*—Clear comprehension 1. *USUALLY UNDERSTANDS*—Misses some part/intent of message, BUT comprehends most conversation with little or no prompting 2. *OFTEN UNDERSTANDS*—Misses some part/intent of message; with prompting can often comprehend conversation 3. *SOMETIMES UNDERSTANDS*—Responds adequately to simple, direct communication 4. *RARELY/NEVER UNDERSTANDS*
4.	COMMUNICATION DECLINE	Worsening in communication (making self understood or understanding others) as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) 0. No 1. Yes

SECTION D. VISION PATTERNS

1.	VISION	*(Ability to see in adequate light and with glasses if used)* 0. *ADEQUATE*—Sees fine detail, including regular print in newspapers/ books 1. *IMPAIRED*—Sees large print, but not regular print in newspapers/ books 2. *MODERATELY IMPAIRED*—Limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—Object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—No vision or sees only light, colors, or shapes; eyes do not appear to follow objects
2.	VISUAL LIMITATION/ DIFFICULTIES	Saw halos or rings around lights, curtains over eyes, or flashes of lights 0. No 1. Yes
3.	VISION DECLINE	Worsening of vision as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) 0. No 1. Yes

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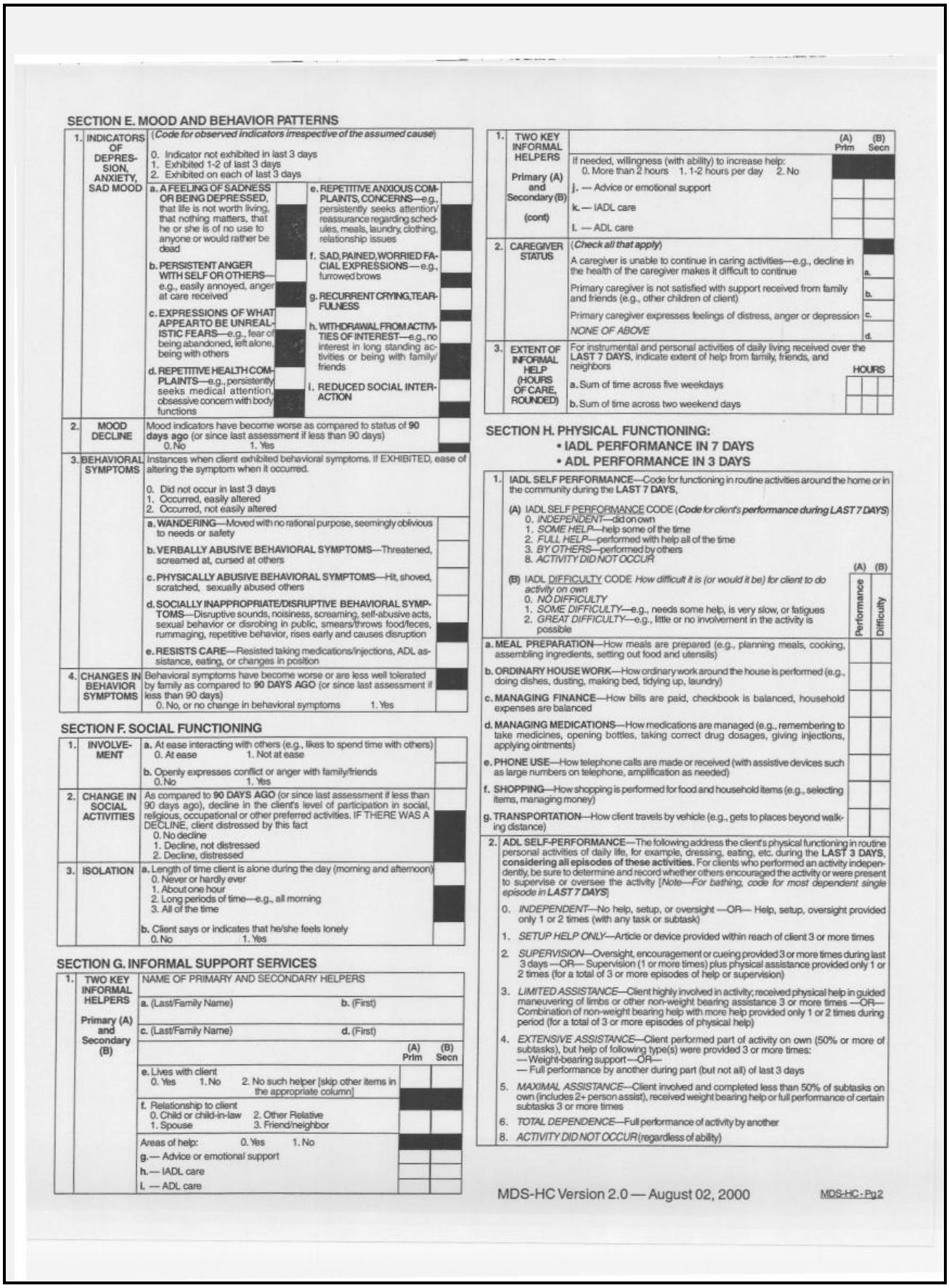

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (*Code for observed indicators irrespective of the assumed cause*)

0. Indicator not exhibited in last 3 days
1. Exhibited 1-2 of last 3 days
2. Exhibited on each of last 3 days

- a. A FEELING OF SADNESS OR BEING DEPRESSED, that life is not worth living, that nothing matters, that he or she is of no use to anyone or would rather be dead
- b. PERSISTENT ANGER WITH SELF OR OTHERS—e.g., easily annoyed, anger at care received
- c. EXPRESSIONS OF WHAT APPEAR TO BE UNREALISTIC FEARS—e.g., fear of being abandoned, left alone, being with others
- d. REPETITIVE HEALTH COMPLAINTS—e.g., persistently seeks medical attention, obsessive concern with body functions
- e. REPETITIVE ANXIOUS COMPLAINTS, CONCERNS—e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues
- f. SAD, PAINED, WORRIED FACIAL EXPRESSIONS—e.g., furrowed brows
- g. RECURRENT CRYING, TEARFULNESS
- h. WITHDRAWAL FROM ACTIVITIES OF INTEREST—e.g., no interest in long standing activities or being with family/friends
- i. REDUCED SOCIAL INTERACTION

2. MOOD DECLINE — Mood indicators have become worse as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No 1. Yes

3. BEHAVIORAL SYMPTOMS — Instances when client exhibited behavioral symptoms. If EXHIBITED, ease of altering the symptom when it occurred.

0. Did not occur in last 3 days
1. Occurred, easily altered
2. Occurred, not easily altered

- a. WANDERING—Moved with no rational purpose, seemingly oblivious to needs or safety
- b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS—Threatened, screamed at, cursed at others
- c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS—Hit, shoved, scratched, sexually abused others
- d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS—Disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smears/throws food/feces, rummaging, repetitive behavior, rises early and causes disruption
- e. RESISTS CARE—Resisted taking medications/injections, ADL assistance, eating, or changes in position

4. CHANGES IN BEHAVIOR SYMPTOMS — Behavioral symptoms have become worse or are less well tolerated by family as compared to **90 DAYS AGO** (or since last assessment if less than 90 days)
0. No, or no change in behavioral symptoms 1. Yes

SECTION F. SOCIAL FUNCTIONING

1. INVOLVEMENT
- a. At ease interacting with others (e.g., likes to spend time with others)
  0. At ease 1. Not at ease
- b. Openly expresses conflict or anger with family/friends
  0. No 1. Yes

2. CHANGE IN SOCIAL ACTIVITIES — As compared to **90 DAYS AGO** (or since last assessment if less than 90 days ago), decline in the client's level of participation in social, religious, occupational or other preferred activities. IF THERE WAS A DECLINE, client distressed by this fact
0. No decline
1. Decline, not distressed
2. Decline, distressed

3. ISOLATION
- a. Length of time client is alone during the day (morning and afternoon)
  0. Never or hardly ever
  1. About one hour
  2. Long periods of time—e.g., all morning
  3. All of the time
- b. Client says or indicates that he/she feels lonely
  0. No 1. Yes

SECTION G. INFORMAL SUPPORT SERVICES

1. TWO KEY INFORMAL HELPERS — Primary (A) and Secondary (B)

NAME OF PRIMARY AND SECONDARY HELPERS

a. (Last/Family Name) b. (First)

c. (Last/Family Name) d. (First)

	(A) Prim	(B) Secn
e. Lives with client (0. Yes 1. No 2. No such helper [skip other items in the appropriate column])		
f. Relationship to client (0. Child or child-in-law 1. Spouse 2. Other Relative 3. Friend/neighbor)		
Areas of help: (0. Yes 1. No)		
g. — Advice or emotional support		
h. — IADL care		
i. — ADL care		

1. TWO KEY INFORMAL HELPERS — Primary (A) and Secondary (B) (cont)

	(A) Prim	(B) Secn
If needed, willingness (with ability) to increase help: 0. More than 2 hours 1. 1-2 hours per day 2. No		
j. — Advice or emotional support		
k. — IADL care		
l. — ADL care		

2. CAREGIVER STATUS (*Check all that apply*)

- A caregiver is unable to continue in caring activities—e.g., decline in the health of the caregiver makes it difficult to continue — a.
- Primary caregiver is not satisfied with support received from family and friends (e.g., other children of client) — b.
- Primary caregiver expresses feelings of distress, anger or depression — c.
- *NONE OF ABOVE* — d.

3. EXTENT OF INFORMAL HELP (HOURS OF CARE, ROUNDED) — For instrumental and personal activities of daily living received over the **LAST 7 DAYS**, indicate extent of help from family, friends, and neighbors

HOURS

- a. Sum of time across five weekdays
- b. Sum of time across two weekend days

SECTION H. PHYSICAL FUNCTIONING:
• IADL PERFORMANCE IN 7 DAYS
• ADL PERFORMANCE IN 3 DAYS

1. IADL SELF PERFORMANCE—Code for functioning in routine activities around the home or in the community during the **LAST 7 DAYS**,

(A) IADL SELF PERFORMANCE CODE (*Code for client's performance during LAST 7 DAYS*)
0. *INDEPENDENT*—did on own
1. *SOME HELP*—help some of the time
2. *FULL HELP*—performed with help all of the time
3. *BY OTHERS*—performed by others
8. *ACTIVITY DID NOT OCCUR*

(B) IADL DIFFICULTY CODE *How difficult it is (or would it be) for client to do activity on own*
0. *NO DIFFICULTY*
1. *SOME DIFFICULTY*—e.g., needs some help, is very slow, or fatigues
2. *GREAT DIFFICULTY*—e.g., little or no involvement in the activity is possible

	(A) Performance	(B) Difficulty
a. MEAL PREPARATION—How meals are prepared (e.g., planning meals, cooking, assembling ingredients, setting out food and utensils)		
b. ORDINARY HOUSEWORK—How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)		
c. MANAGING FINANCE—How bills are paid, checkbook is balanced, household expenses are balanced		
d. MANAGING MEDICATIONS—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)		
e. PHONE USE—How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)		
f. SHOPPING—How shopping is performed for food and household items (e.g., selecting items, managing money)		
g. TRANSPORTATION—How client travels by vehicle (e.g., gets to places beyond walking distance)		

2. ADL SELF-PERFORMANCE—The following address the client's physical functioning in routine personal activities of daily life, for example, dressing, eating, etc. during the **LAST 3 DAYS, considering all episodes of these activities.** For clients who performed an activity independently, be sure to determine and record whether others encouraged the activity or were present to supervise or oversee the activity [*Note—For bathing, code for most dependent single episode in LAST 7 DAYS*]

0. *INDEPENDENT*—No help, setup, or oversight —OR— Help, setup, oversight provided only 1 or 2 times (with any task or subtask)
1. *SETUP HELP ONLY*—Article or device provided within reach of client 3 or more times
2. *SUPERVISION*—Oversight, encouragement or cueing provided 3 or more times during last 3 days —OR— Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision)
3. *LIMITED ASSISTANCE*—Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times —OR— Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help)
4. *EXTENSIVE ASSISTANCE*—Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times:
   — Weight-bearing support —OR—
   — Full performance by another during part (but not all) of last 3 days
5. *MAXIMAL ASSISTANCE*—Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times
6. *TOTAL DEPENDENCE*—Full performance of activity by another
8. *ACTIVITY DID NOT OCCUR* (regardless of ability)

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2.	ADL SELF-PERFORMANCE (cont)	
	a. MOBILITY IN BED—Including moving to and from lying position, turning side to side, and positioning body while in bed.	
	b. TRANSFER—Including moving to and between surfaces—to/from bed, chair, wheelchair, standing position. [*Note—Excludes to/from bath/toilet*]	
	c. LOCOMOTION IN HOME—[Note—If in wheelchair, self-sufficiency once in chair]	
	d. LOCOMOTION OUTSIDE OF HOME—[Note—If in wheelchair, self-sufficiency once in chair]	
	e. DRESSING UPPER BODY—How client dresses and undresses (**street clothes, underwear**) above the waist, includes prostheses, orthotics, fasteners, pullovers, etc.	
	f. DRESSING LOWER BODY—How client dresses and undresses (**street clothes, underwear**) from the waist down, includes prostheses, orthotics, belts, pants, skirts, shoes, and fasteners	
	g. EATING—Including taking in food by any method, including tube feedings.	
	h. TOILET USE—Including using the toilet room or commode, bedpan, urinal, transferring on/off toilet, cleaning self after toilet use or incontinent episode, changing pad, managing any special devices required (ostomy or catheter), and adjusting clothes.	
	i. PERSONAL HYGIENE—Including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (EXCLUDE baths and showers)	
	j. BATHING—How client takes full-body bath/shower or sponge bath (**EXCLUDE** washing of back and hair). Includes how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area. ***Code for most dependent episode in LAST 7 DAYS***	
3.	ADL DECLINE — ADL status has become worse (i.e., now more impaired in self performance) as compared to status **90 days ago** (or since last assessment if less than 90 days) 0. No 1. Yes	
4.	PRIMARY MODES OF LOCOMOTION — 0. No assistive device 3. Scooter (e.g., Amigo) 1. Cane 4. Wheelchair 2. Walker/crutch 8. ACTIVITY DID NOT OCCUR	
	a. Indoors	
	b. Outdoors	
5.	STAIR CLIMBING — In the **last 3 days**, how client went up and down stairs (e.g., single or multiple steps, using handrail as needed) 0. Up and down stairs without help 1. Up and down stairs with help 2. Not go up and down stairs	
6.	STAMINA — a. In a typical week, during the **LAST 30 DAYS** (or since last assessment), code the number of days client usually went out of the house or building in which client lives (no matter how short a time period) 0. Every day 2. 1 day a week 1. 2-6 days a week 3. No days	
	b. Hours of physical activities in the **last 3 days** (e.g., walking, cleaning house, exercise) 0. Two or more hours 1. Less than two hours	
7.	FUNCTIONAL POTENTIAL — Client believes he/she capable of increased functional independence (ADL, IADL, mobility)	a.
	Caregivers believe client is capable of increased functional independence (ADL, IADL, mobility)	b.
	Good prospects of recovery from current disease or conditions, improved health status expected	c.
	NONE OF ABOVE	d.

SECTION I. CONTINENCE IN LAST 7 DAYS

1.	BLADDER CONTINENCE	a. **In LAST 7 DAYS** control of urinary bladder function (with appliances such as catheters or incontinence program employed) [Note—if dribbles, volume insufficient to soak through underpants] 0. *CONTINENT*—Complete control; DOES NOT USE any type of catheter or other urinary collection device 1. *CONTINENT WITH CATHETER*—Complete control with use of any type of catheter or urinary collection device that does not leak urine 2. *USUALLY CONTINENT*—Incontinent episodes once a week or less 3. *OCCASIONALLY INCONTINENT*—Incontinent episodes 2 or more times a week but not daily 4. *FREQUENTLY INCONTINENT*—Tends to be incontinent daily, but some control present 5. *INCONTINENT*—Inadequate control, multiple daily episodes 8. *DID NOT OCCUR*—No urine output from bladder	
		b. Worsening of bladder incontinence as compared to status **90 DAYS AGO** (or since last assessment if less than 90 days) 0. No 1. Yes	
2.	BLADDER DEVICES	(***Check all that apply in LAST 7 DAYS***)	
		Use of pads or briefs to protect against wetness	a.
		Use of an indwelling urinary catheter	b.
		NONE OF ABOVE	c.

3.	BOWEL CONTINENCE	In **LAST 7 DAYS**, control of bowel movement (with appliance or bowel continence program if employed) 0. *CONTINENT*—Complete control; DOES NOT USE ostomy device 1. *CONTINENT WITH OSTOMY*—Complete control with use of ostomy device that does not leak stool 2. *USUALLY CONTINENT*—Bowel incontinent episodes less than weekly 3. *OCCASIONALLY INCONTINENT*—Bowel incontinent episode once a week 4. *FREQUENTLY INCONTINENT*—Bowel incontinent episodes 2-3 times a week 5. *INCONTINENT*—Bowel incontinent all (or almost all) of the time 8. *DID NOT OCCUR*—No bowel movement during entire 7 day assessment period	

SECTION J. DISEASE DIAGNOSES

Disease/infection that doctor has indicated is present and affects client's status, requires treatment, or symptom management. Also include if disease is monitored by a home care professional or is the reason for a hospitalization in **LAST 90 DAYS** (or since last assessment if less than 90 days)

[blank]. Not present
1. Present—not subject to focused treatment or monitoring by home care professional
2. Present—monitored or treated by home care professional

[If no disease in list, check **J1ac**, *None of Above*]

1.	DISEASES				
		HEART/CIRCULATION		p. Osteoporosis	
		a. Cerebrovascular accident (stroke)		**SENSES**	
		b. Congestive heart failure		q. Cataract	
		c. Coronary artery disease		r. Glaucoma	
		d. Hypertension		**PSYCHIATRIC/MOOD**	
		e. Irregularly irregular pulse		s. Any psychiatric diagnosis	
		f. Peripheral vascular disease		**INFECTIONS**	
		NEUROLOGICAL		t. HIV infection	
		g. Alzheimer's		u. Pneumonia	
		h. Dementia other than Alzheimer's disease		v. Tuberculosis	
		i. Head trauma		w. Urinary tract infection (**in LAST 30 DAYS**)	
		j. Hemiplegia/hemiparesis		**OTHER DISEASES**	
		k. Multiple sclerosis		x. Cancer—(in past 5 years) not including skin cancer	
		l. Parkinsonism		y. Diabetes	
		MUSCULO-SKELETAL		z. Emphysema/COPD/asthma	
		m. Arthritis		aa. Renal Failure	
		n. Hip fracture		ab. Thyroid disease (hyper or hypo)	
		o. Other fractures (e.g., wrist, vertebral)		ac. *NONE OF ABOVE*	ac.
2.	OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES	a. _____			
		b. _____			
		c. _____			
		d. _____			

SECTION K. HEALTH CONDITIONS AND PREVENTIVE HEALTH MEASURES

1.	PREVENTIVE HEALTH (PAST TWO YEARS)	(***Check all that apply—in PAST 2 YEARS***)	
		Blood pressure measured	a.
		Received influenza vaccination	b.
		Test for blood in stool or screening endoscopy	c.
		IF FEMALE: Received breast examination or mammography	d.
		NONE OF ABOVE	e.
2.	PROBLEM CONDITIONS PRESENT ON 2 OR MORE DAYS	(***Check all that were present on at least 2 of the last 3 days***)	
		Diarrhea	a.
		Difficulty urinating or urinating 3 or more times at night	b.
		Fever	c.
		Loss of appetite	d.
		Vomiting	e.
		NONE OF ABOVE	f.
3.	PROBLEM CONDITIONS	(***Check all present at any point during last 3 days***)	
		PHYSICAL HEALTH	
		Chest pain/pressure at rest or on exertion	a.
		No bowel movement in 3 days	b.
		Dizziness or lightheadedness	c.
		Edema	d.
		Shortness of breath	e.
		MENTAL HEALTH	
		Delusions	f.
		Hallucinations	g.
		NONE OF ABOVE	h.

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4.	PAIN	a. Frequency with which client complains or shows evidence of pain 0. No pain (score b–e as 0) 2. Daily - one period 1. Less than daily 3. Daily - multiple periods (e.g., morning and evening)	
		b. Intensity of pain 0. No pain 2. Moderate 4. Times when pain is horrible 1. Mild 3. Severe or excruciating	
		c. From client's point of view, pain intensity disrupts usual activities 0. No 1. Yes	
		d. Character of pain 0. No pain 1. Localized - single site 2. Multiple sites	
		e. From client's point of view, medications adequately control pain 0. Yes or no pain 1. Medications do not adequately control pain 2. Pain present, medication not taken	
5.	FALLS FREQUENCY	Number of times fell in **LAST 90 DAYS** (or since last assessment if less than 90 days) If none, code "0"; if more than 9, code "9"	
6.	DANGER OF FALL	(*Code for danger of falling*) 0. No 1. Yes	
		a. Unsteady gait	
		b. Client limits going outdoors due to fear of falling (e.g., stopped using bus, goes out only with others)	
7.	LIFE STYLE (Drinking/ Smoking)	(*Code for drinking or smoking*) 0. No 1. Yes	
		a. **In the LAST 90 DAYS** (or since last assessment if less than 90 days), client felt the need or was told by others to cut down on drinking, or others were concerned with client's drinking	
		b. **In the LAST 90 DAYS** (or since last assessment if less than 90 days), client had to have a drink first thing in the morning to steady nerves (i.e., an "eye opener") or has been in trouble because of drinking	
		c. Smoked or chewed tobacco daily	
8.	HEALTH STATUS INDICATORS	(**Check all that apply**)	
		Client feels he/she has poor health (when asked)	a.
		Has conditions or diseases that make cognition, ADL, mood, or behavior patterns unstable (fluctuations, precarious, or deteriorating)	b.
		Experiencing a flare-up of a recurrent or chronic problem	c.
		Treatments changed in **LAST 30 DAYS** (or since last assessment if less than 30 days) because of a new acute episode or condition	d.
		Prognosis of less than six months to live—e.g., physician has told client or client's family that client has end-stage disease	e.
		NONE OF ABOVE	f.
9.	OTHER STATUS INDICATORS	(**Check all that apply**)	
		Fearful of a family member or caregiver	a.
		Unusually poor hygiene	b.
		Unexplained injuries, broken bones, or burns	c.
		Neglected, abused, or mistreated	d.
		Physically restrained (e.g., limbs restrained, used bed rails, constrained to chair when sitting)	e.
		NONE OF ABOVE	f.

SECTION L. NUTRITION/HYDRATION STATUS

1.	WEIGHT	(*Code for weight items*) 0. No 1. Yes	
		a. Unintended weight loss of 5% or more in the **LAST 30 DAYS** [or 10% or more in the **LAST 180 DAYS**]	
		b. Severe malnutrition (cachexia)	
		c. Morbid obesity	
2.	CONSUMPTION	(*Code for consumption*) 0. No 1. Yes	
		a. **In at least 2 of the last 3 days,** ate one or fewer meals a day	
		b. **In last 3 days,** noticeable decrease in the amount of food client usually eats or fluids usually consumes	
		c. Insufficient fluid—did not consume all/almost all fluids during last 3 days	
		d. Enteral tube feeding	
3.	SWALLOWING	0. *NORMAL*—Safe and efficient swallowing of all diet consistencies 1. *REQUIRES DIET MODIFICATION TO SWALLOW SOLID FOODS* (mechanical diet or able to ingest specific foods only) 2. *REQUIRES MODIFICATION TO SWALLOW SOLID FOODS AND LIQUIDS* (puree, thickened liquids) 3. *COMBINED ORAL AND TUBE FEEDING* 4. *NO ORAL INTAKE (NPO)*	

SECTION M. DENTAL STATUS (ORAL HEALTH)

1.	ORAL STATUS	(**Check all that apply**)	
		Problem chewing (e.g., poor mastication, immobile jaw, surgical resection, decreased sensation/motor control, pain while eating)	a.
		Mouth is "dry" when eating a meal	b.
		Problem brushing teeth or dentures	c.
		NONE OF ABOVE	d.

SECTION N. SKIN CONDITION

1.	SKIN PROBLEMS	Any troubling skin conditions or changes in skin condition (e.g., burns, bruises, rashes, itchiness, body lice, scabies) 0. No 1. Yes	
2.	ULCERS (Pressure/ Stasis)	Presence of an ulcer anywhere on the body. Ulcers include any area of persistent skin redness (Stage 1); partial loss of skin layers (Stage 2); deep craters in the skin (Stage 3); breaks in skin exposing muscle or bone (Stage 4). [**Code 0 if no ulcer, otherwise record the highest ulcer stage (Stage 1-4).**]	
		a. **Pressure ulcer**—any lesion caused by pressure, shear forces, resulting in damage of underlying tissues	
		b. **Stasis ulcer**—open lesion caused by poor circulation in the lower extremities	
3.	OTHER SKIN PROBLEMS REQUIRING TREATMENT	(*Check all that apply*)	
		Burns (second or third degree)	a.
		Open lesions other than ulcers, rashes, cuts (e.g., cancer)	b.
		Skin tears or cuts	c.
		Surgical wound	d.
		Corns, calluses, structural problems, infections, fungi	e.
		NONE OF ABOVE	f.
4.	HISTORY OF RESOLVED PRESSURE ULCERS	Client previously had (at any time) or has an ulcer anywhere on the body 0. No 1. Yes	
5.	WOUND/ ULCER CARE	(*Check for formal care in LAST 7 DAYS*)	
		Antibiotics, systemic or topical	a.
		Dressings	b.
		Surgical wound care	c.
		Other wound/ulcer care (e.g., pressure relieving device, nutrition, turning, debridement)	d.
		NONE OF ABOVE	e.

SECTION O. ENVIRONMENTAL ASSESSMENT

1.	HOME ENVIRONMENT [Check any of following that make home environment hazardous or uninhabitable (if none apply, check *NONE OF ABOVE*; if temporarily in institution, base assessment on home visit)]	Lighting in evening (including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors)	a.
		Flooring and carpeting (e.g., holes in floor, electric wires where client walks, scatter rugs)	b.
		Bathroom and toiletroom (e.g., non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet)	c.
		Kitchen (e.g., dangerous stove, inoperative refrigerator, infestation by rats or bugs)	d.
		Heating and cooling (e.g., too hot in summer, too cold in winter, wood stove in a home with an asthmatic)	e.
		Personal safety (e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street)	f.
		Access to home (e.g., difficulty entering/leaving home)	g.
		Access to rooms in house (e.g., unable to climb stairs)	h.
		NONE OF ABOVE	i.
2.	LIVING ARRANGEMENT	a. As compared to **90 DAYS AGO** (or since last assessment), client now lives with other persons—e.g., moved in with another person, other moved in with client 0. No 1. Yes	
		b. Client or primary caregiver feels that client would be better off in another living environment 0. No 1. Client only 2. Caregiver only 3. Client and caregiver	

SECTION P. SERVICE UTILIZATION (IN LAST 7 DAYS)

1.	FORMAL CARE (Minutes rounded to even 10 minutes)	Extent of care or care management in **LAST 7 DAYS** (or since last assessment if less than 7 days) involving	(A) # of Days	(B) Hours	(C) Mins
		a. Home health aides			
		b. Visiting nurses			
		c. Homemaking services			
		d. Meals			
		e. Volunteer services			
		f. Physical therapy			
		g. Occupational therapy			
		h. Speech therapy			
		i. Day care or day hospital			
		j. Social worker in home			

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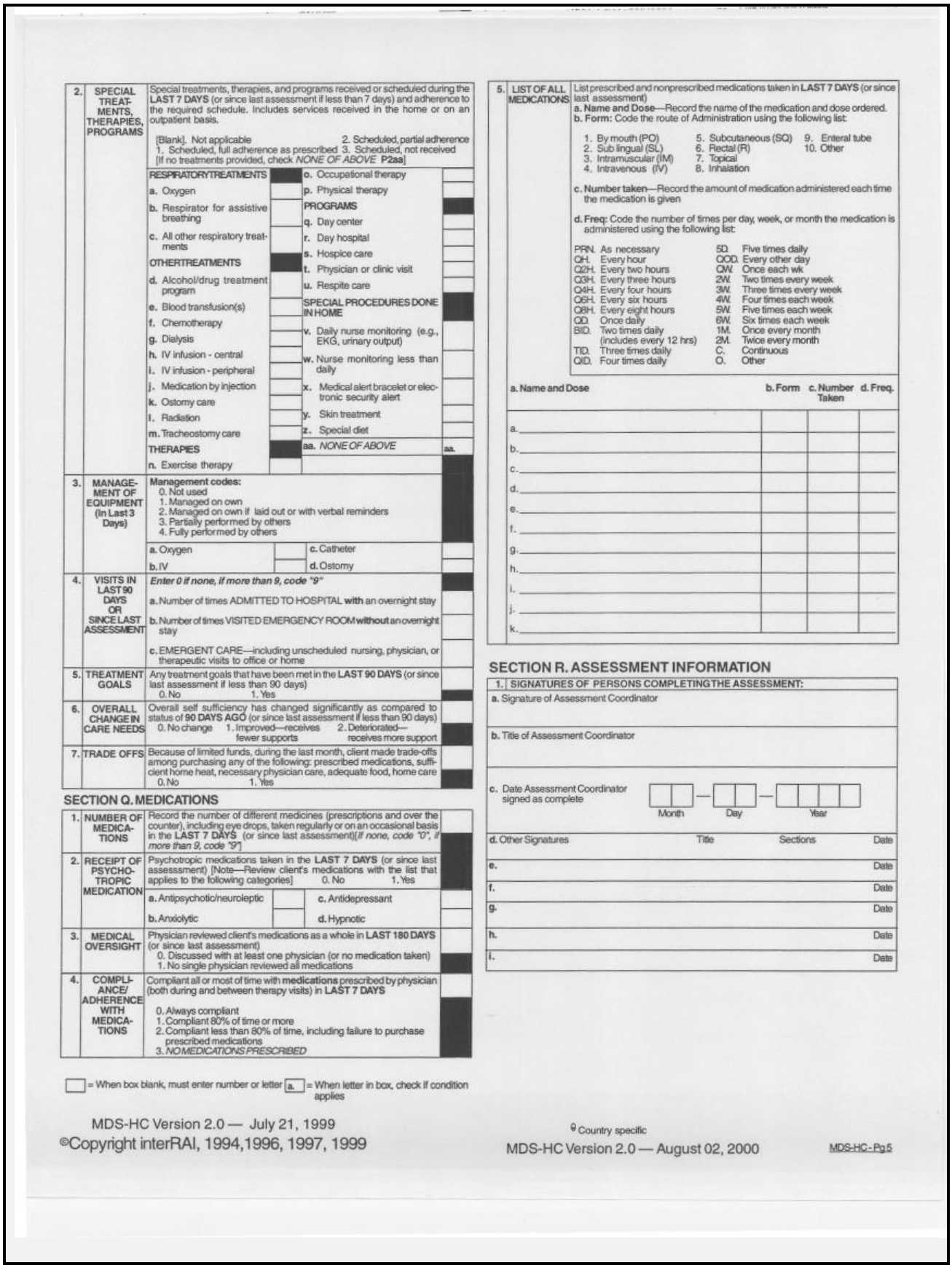

2. SPECIAL TREATMENTS, THERAPIES, PROGRAMS

Special treatments, therapies, and programs received or scheduled during the **LAST 7 DAYS** (or since last assessment if less than 7 days) and adherence to the required schedule. Includes services received in the home or on an outpatient basis.

[Blank]. Not applicable
1. Scheduled, full adherence as prescribed
2. Scheduled, partial adherence
3. Scheduled, not received
[If no treatments provided, check *NONE OF ABOVE* **P2aa**]

RESPIRATORY TREATMENTS
- a. Oxygen
- b. Respirator for assistive breathing
- c. All other respiratory treatments

OTHER TREATMENTS
- d. Alcohol/drug treatment program
- e. Blood transfusion(s)
- f. Chemotherapy
- g. Dialysis
- h. IV infusion - central
- i. IV infusion - peripheral
- j. Medication by injection
- k. Ostomy care
- l. Radiation
- m. Tracheostomy care

THERAPIES
- n. Exercise therapy
- o. Occupational therapy
- p. Physical therapy

PROGRAMS
- q. Day center
- r. Day hospital
- s. Hospice care

- t. Physician or clinic visit
- u. Respite care

SPECIAL PROCEDURES DONE IN HOME
- v. Daily nurse monitoring (e.g., EKG, urinary output)
- w. Nurse monitoring less than daily
- x. Medical alert bracelet or electronic security alert
- y. Skin treatment
- z. Special diet
- aa. *NONE OF ABOVE*

3. MANAGEMENT OF EQUIPMENT (In Last 3 Days)

Management codes:
0. Not used
1. Managed on own
2. Managed on own if laid out or with verbal reminders
3. Partially performed by others
4. Fully performed by others

- a. Oxygen
- b. IV
- c. Catheter
- d. Ostomy

4. VISITS IN LAST 90 DAYS OR SINCE LAST ASSESSMENT

Enter 0 if none, if more than 9, code "9"

- a. Number of times ADMITTED TO HOSPITAL **with** an overnight stay
- b. Number of times VISITED EMERGENCY ROOM **without** an overnight stay
- c. EMERGENT CARE—including unscheduled nursing, physician, or therapeutic visits to office or home

5. TREATMENT GOALS

Any treatment goals that have been met in the **LAST 90 DAYS** (or since last assessment if less than 90 days)
0. No 1. Yes

6. OVERALL CHANGE IN CARE NEEDS

Overall self sufficiency has changed significantly as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days)
0. No change 1. Improved—receives fewer supports 2. Deteriorated—receives more support

7. TRADE OFFS

Because of limited funds, during the last month, client made trade-offs among purchasing any of the following: prescribed medications, sufficient home heat, necessary physician care, adequate food, home care
0. No 1. Yes

SECTION Q. MEDICATIONS

1. NUMBER OF MEDICATIONS

Record the number of different medicines (prescriptions and over the counter), including eye drops, taken regularly or on an occasional basis in the **LAST 7 DAYS** (or since last assessment)[*If none, code "0", if more than 9, code "9"*]

2. RECEIPT OF PSYCHOTROPIC MEDICATION

Psychotropic medications taken in the **LAST 7 DAYS** (or since last assesssment) [Note—Review client's medications with the list that applies to the following categories] 0. No 1. Yes

- a. Antipsychotic/neuroleptic
- b. Anxiolytic
- c. Antidepressant
- d. Hypnotic

3. MEDICAL OVERSIGHT

Physician reviewed client's medications as a whole in **LAST 180 DAYS** (or since last assessment)
0. Discussed with at least one physician (or no medication taken)
1. No single physician reviewed all medications

4. COMPLIANCE/ ADHERENCE WITH MEDICATIONS

Compliant all or most of time with **medications** prescribed by physician (both during and between therapy visits) in **LAST 7 DAYS**
0. Always compliant
1. Compliant 80% of time or more
2. Compliant less than 80% of time, including failure to purchase prescribed medications
3. *NO MEDICATIONS PRESCRIBED*

5. LIST OF ALL MEDICATIONS

List prescribed and nonprescribed medications taken in **LAST 7 DAYS** (or since last assessment)
a. Name and Dose—Record the name of the medication and dose ordered.
b. Form: Code the route of Administration using the following list:

1. By mouth (PO)
2. Sub lingual (SL)
3. Intramuscular (IM)
4. Intravenous (IV)
5. Subcutaneous (SQ)
6. Rectal (R)
7. Topical
8. Inhalation
9. Enteral tube
10. Other

c. Number taken—Record the amount of medication administered each time the medication is given

d. Freq: Code the number of times per day, week, or month the medication is administered using the following list:

PRN.	As necessary	5D.	Five times daily
QH.	Every hour	QOD.	Every other day
Q2H.	Every two hours	QW.	Once each wk
Q3H.	Every three hours	2W.	Two times every week
Q4H.	Every four hours	3W.	Three times every week
Q6H.	Every six hours	4W.	Four times each week
Q8H.	Every eight hours	5W.	Five times each week
QD.	Once daily	6W.	Six times each week
BID.	Two times daily (includes every 12 hrs)	1M.	Once every month
		2M.	Twice every month
TID.	Three times daily	C.	Continuous
QID.	Four times daily	O.	Other

a. Name and Dose	b. Form	c. Number Taken	d. Freq.
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			
i.			
j.			
k.			

SECTION R. ASSESSMENT INFORMATION

1. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:

a. Signature of Assessment Coordinator

b. Title of Assessment Coordinator

c. Date Assessment Coordinator signed as complete — Month — Day — Year

d. Other Signatures	Title	Sections	Date
e.			Date
f.			Date
g.			Date
h.			Date
i.			Date

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

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Attachment #1 to Appendix B-7

Home and Community-Based Services
FREEDOM OF CHOICE
CONSENT FORM

Applicant Name _____ Social Security Number_____

I have been fully informed of services available through the Medicaid Home and Community-Based Services Waiver Program. I have also been fully informed of services available in a nursing facility.

I have been advised that if my needs cannot be adequately and safely met in the community, I will not be offered waiver services.

I have also been advised that if while on the waiver my condition deteriorates to the point that I cannot be maintained safely in the community, waiver services will be terminated.

I have been fully informed that I will be given the opportunity to choose the provider of service(s) when more than one provider is available to render the service(s).

After receiving explanations regarding the choices available, I freely choose to:

___ Receive services through the Medicaid Home and Community-Based Waiver Program. Services will be provided in the community setting.

___ Receive services in an institutional setting. Services will be provided in a nursing facility.

___ Receive services in the community through DSPD's state funded program if funding is available.

___ Not receive services at this time.

Comments: _____

_____

_____ _____
APPLICANT'S SIGNATURE DATE

_____ _____
CASE MANAGER'S SIGNATURE DATE

STATE: UTAH D-9 EFFECTIVE DATE: July 1, 1998

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *Complete the following table by listing the services that are furnished under this waiver. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services			
Service	Included	Not Included	Alternate Service Title (if any)
Case Management	○	○	
Homemaker	○	○	
Home Health Aide	○	○	
Personal Care	✓	○	Personal Assistance Services
Adult Day Health	○	○	
Habilitation	○	○	
Residential Habilitation	○	○	
Day Habilitation	○	○	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):			
Prevocational Services	○	○	
Supported Employment	○	○	
Education	○	○	
Respite	○	○	
Day Treatment	○	○	
Partial Hospitalization	○	○	
Psychosocial Rehabilitation	○	○	
Clinic Services	○	○	
Live-in Caregiver (42 CFR §441.303(f)(8))	○	○	

Other Services	
○	Not applicable
✓	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute:
a.	Personal Emergency Response Systems (purchase, installation, testing and service fees)
b.	Local Area Support Coordination Liaison
c.	

d.	
e.	
f.	
g.	
h.	
i.	

Extended State Plan Services

✓	Not applicable
○	The following extended State plan services are provided:
a.	
b.	
c.	

Services in Support of Participant Direction

✓	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following services to support participant direction of services.
○	Not applicable

Support	Included	Not Included	Alternate Service Title (if any)
Supports for Participant Direction	✓	○	Consumer Preparation Services
Financial Management Services	✓	○	
Other Support Service	○	○	

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not included as a waiver service, indicate how case management is furnished to waiver participants *(check each that applies)*:

☐	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
✓	As an administrative activity. *Complete item C-1-c.*
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants.

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management on behalf of waiver participants:

Administrative Case Management Services are provided by the Utah licensed registered nurses employed by the Operating Agency (DSPD)

Appendix C-2: General Service Specifications

a. Criminal History and/or Background Investigations. Specify State policies concerning the conducting of criminal history and/or background investigations of individuals who provide waiver services to participants *(select one)*:

✓	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., direct support professionals) for whom such investigations must be conducted; (b) the scope of such investigations (e.g., state or national); and, (c) the State process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available through the Medicaid or operating agency (if applicable):
	UCA 62-2-120 and R501-14 of the Utah Human Services Administration requires all persons having direct access to children or vulnerable adults must undergo a criminal history/ background investigation except in the case where the waiver enrollee has chosen to self-employ a family member as part of their self directed program. If the person has lived in Utah continuously for 5 years or more a regional check is conducted. For those not having lived in Utah for 5 continuous years a national check through the FBI is conducted.
○	**No**. Criminal history/background investigations are not required.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services to participants through a State-maintained abuse registry *(select one)*:

✓	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for whom abuse registry screenings must be conducted; and, (c) the State process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available through the Medicaid agency or operating agency (if applicable):
	UCA 62-2-120 and R501-14 of the Utah Human Services Administration requires all persons having direct access to children or vulnerable adults must undergo an abuse screening except in the case where the waiver enrollee has chosen to self-employ a family member as part of their self directed program. The Utah Division of Aging and Adult Services and The Utah Division of Child and Family Services maintain these abuse registries.
○	**No**. The State does not conduct abuse registry screening.

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one*:

✓	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete items c.i – c.ii.*
○	**Yes**. Home and community-based are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available through the Medicaid agency or other operating agency (if applicable). *Complete items c.i –c.ii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit

ii. Larger Facilities: For residential facilities that serve four or more unrelated individuals, describe how a home and community character is maintained in these settings.

iii. Scope of State Facility Standards. By type of facility listed in item C-2-c-I, specify whether the State standards address the following topics *(check all that apply)*:

Standard	Facility Type	Facility Type	Facility Type	Facility Type
Admission policies	☐	☐	☐	☐
Physical environment	☐	☐	☐	☐
Sanitation	☐	☐	☐	☐
Safety	☐	☐	☐	☐
Staff : resident ratios	☐	☐	☐	☐
Staff training and qualifications	☐	☐	☐	☐
Staff supervision	☐	☐	☐	☐
Resident rights	☐	☐	☐	☐
Medication administration	☐	☐	☐	☐
Use of Restrictive Procedures	☐	☐	☐	☐
Incident reporting	☐	☐	☐	☐
Provision of or arrangement for necessary health services	☐	☐	☐	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area:

d. Provision of Services by Individuals Who are Otherwise Legally Responsible to Provide Care. A legally responsible individual is anyone so defined by State law and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child with designated responsibilities to provide care to a minor child who is a waiver participant or (b) the spouse of a waiver participant. Except in extraordinary circumstances, payment may not be made to a legally responsible individual for the provision of personal care services that the legally responsible individual would ordinarily perform or be responsible to perform. When the State makes payment to legally responsible individuals for furnishing personal care services, it must specify the extraordinary circumstances under which such payments are made. *Select one:*

✓	**No**. The State does not make payment to legally responsible individuals for furnishing personal care services.
○	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care services. Specify the services for which such payment may be made, the legally responsible individual(s) who may furnish such services, State policies that describe the extraordinary circumstances when such payments may be authorized and the controls that are employed to ensure that payments are made only for services rendered:

e. Additional State Policies Concerning Waiver Services Furnished by Family Members. Specify any additional State policies concerning making payment to family members for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○	The State does not make payment to family members for furnishing waiver services.
○	The State makes payment to family members under exceptional circumstances. Specify the exceptional circumstances and the waiver services for which payment may be made to family members, including the types of family members to which payment may be made.
✓	Family members may be paid for providing waiver services whenever the family member is qualified to provide service.
○	Other policy. *Specify*:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers:

The Utah Department of Health will enter into a provider agreement with all willing providers who are selected by recipients and meet licensure, certification and/or other competency requirements.

The Utah Department of Human Services in conjunction with the Bureau of Contract Management will issue a Request for Proposal (RFP) for the purpose of entering into a contract with qualified individuals and public or private non-profit organizations.

The RFP is posted on the Department of Human Services website and will remain open until the closing date specified in the request. The request includes service requirements and expectations. A review committee evaluates the proposals against the criteria contained in the RFP and selects those who meet the qualifications.

Participants utilizing the self administered services model conduct independent recruitment activities.

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available through the Medicaid agency or other operating agency (if applicable).

Service Title:	Local Area Support Coordination Liaison
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
✓	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition:

This service involves: (a) assisting a waiver recipient to identify local area waiver services providers, community based resources, natural supports and to make informed choices when multiple options are available to fulfill the individual's plan of care; (b) establishing a periodic liaison schedule with the recipient as part of the individualized care plan based on assessed need for ongoing localized support; (c) providing the State Administrative RN Case Manager with routine recipient status updates on a periodic basis and immediate notification in the event of substantial changes in the recipient's health, safety, local waiver program environment, or requests for changes in recipient services; and (d) participating in quality assurance evaluations of local waiver services, community based resources, natural supports and the waiver program as a whole, as it pertains to the local area.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limits on the amount, frequency and/or duration are specified on the individual's plan of care and based on assessed need.

Provider Category(s) *(check one or both)*:	✓	**Individual.** List types:	✓	**Agency.** List the types of agencies:
	Individual Medicaid provider contracted to provide Local Area Support Coordination Liaison.		Independent Living Centers	

Provider Qualifications (*Provide the following information for each type of provider)*:

Provider Type:	**License** *(specify)*	**Certificate** *(specify)*	**Other Standard** *(specify)*
			Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA
			An organization structured as an Independent Living Center consistent with definitions and standards set forth in 29 USC Sec. 796a thru 796f.

	Provider Type:	**Entity Responsible:**	**Frequency**

Verification of Provider Qualifications	Provider Type:	Entity Responsible:	Frequency
	Local Area Support Coordination Liaison	**DSPD**	**Annually**

Service Delivery Method *(check each that applies)*:	✓	Participant-directed as specified in Appendix E	✓	Provider managed

Service Title:	Consumer Preparation Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

✓	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition:

This service is designed to ensure that waiver recipients are prepared to supervise and direct their personal assistance provider services. Consumer Preparation Services includes: (a) instruction in methods of identifying need and effectively communicating those needs to service providers; (b) instruction in management of personal attendant(s) including interviewing, selecting, scheduling, termination, time sheeting, evaluating performance, back up coverage; (c) instruction in addressing problems such as changing levels of personal needs, grievance procedures, emergency coverage, exploitation and abuse. Consumer Preparation Services do not include educational, vocational or prevocational components.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limits on the amount, frequency and/or duration are specified on the individual's plan of care and based on assessed need.

Provider Category(s) *(check one or both)*:	✓	**Individual.** List types:	✓	**Agency.** List the types of agencies:
		Individuals holding a valid Division of Services for People with Disabilities state qualified provider contract and have entered into a Medicaid Provider Agreement with the State Medicaid Agency.		Independent Living Centers

Provider Qualifications (*Provide the following information for each type of provider)*:

Provider Type:	**License** *(specify)*	**Certificate** *(specify)*	**Other Standard** *(specify)*
			An organization structured as an Independent Living Center consistent with definitions and standards set forth in 29 USC Sec. 796a thru 796f.

Verification of Provider Qualifications	**Provider Type:**	**Entity Responsible:**	**Frequency**
	Consumer Preparation	**DSPD**	**Annually**

Service Delivery Method *(check each that applies)*:	✓	Participant-directed as specified in Appendix E	✓	Provider managed

Service Title:	Personal Assistance Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
✓	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition:

Personal Assistance Services are essential to help the waiver recipient achieve maximum independence and may vary depending on the needs of the individual and daily schedule. Services may include: (a) hands-on care of both a medical and non-medical supportive nature, specific to the needs of a medically stable, physically handicapped individual. Skilled medical care and health maintenance may be provided only as permitted by State law and certified by the recipient's physician; (b) housekeeping, chore services and other reasonable and necessary activities which are incidental to the performance of the recipient's care may also be furnished as part of this service when agreed upon by the recipient, personal attendant and the case manager, as outlined in the plan of care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limits on the amount, frequency and/or duration are specified on the individual's plan of care and based on assessed need.

Provider Category(s) *(check one or both)*:	✓ **Individual.** List types:	☐ **Agency.** List the types of agencies:
	Qualified individual selected by the recipient and has a joint DSPD contract/Medicaid Provider Agreement	

Provider Qualifications (*Provide the following information for each type of provider)*:

Provider Type:	**License** *(specify)*	**Certificate** *(specify)*	**Other Standard** *(specify)*
Personal Attendant		Home Health Aide Certificate of Completion (R432-700-22)	be at least 18 years of age; have a Social Security Number and provide verification of such; agree to have a Criminal Background Check; have the ability to read, understand and carry out written and verbal instructions, write simple clinical notes and record messages; be trained in First Aid; be oriented and trained in all aspects of care to be provided to the recipient, including medical care and health maintenance; be able to demonstrate competency in all areas of responsibility.

Verification of Provider Qualifications	Provider Type:	Entity Responsible:	Frequency
	Personal Attendant	**DSPD/Waiver Recipient**	**Prior to the delivery of Medicaid Personal Assistance Services**

Service Delivery Method *(check each that applies)*:	✓	Participant-directed as specified in Appendix E	☐	Provider managed

Service Title:	Personal Emergency Response Systems (PERS)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
✓	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition:

This is an electronic device that enables certain individuals at high risk of institutionalization to secure help in the event of an emergency. The individual may also wear a portable "help" button to allow for mobility.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

PERS services are limited to those individuals who live alone, live with others who are not capable of responding in an emergency or who are alone for significant parts of the day and have no regular caretaker for extended periods of time, and who would otherwise require extensive routine supervision.

Provider Category(s) *(check one or both)*:	✓	**Individual.** List types:	✓	**Agency.** List the types of agencies:
	Individuals holding a valid Division of Services for People with Disabilities state qualified provider contract and have entered into a Medicaid Provider Agreement with the State Medicaid Agency.		Individuals holding a valid Division of Services for People with Disabilities state qualified provider contract and have entered into a Medicaid Provider Agreement with the State Medicaid Agency.	

Provider Qualifications (*Provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
PERS	Current business license	FCC registration of equipment placed in the home.	

Verification of Provider Qualifications	Provider Type:	Entity Responsible:	Frequency
	PERS	**DSPD**	**Annually**

Service Delivery Method *(check each that applies)*:	✓	Participant-directed as specified in Appendix E	✓	Provider managed

Service Title:	Financial Management Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
✓	Service is not included in the current waiver.

Service Definition:

This service is offered in support of the self-administered services delivery system. Services rendered under this definition include those to facilitate the employment of personal attendants or assistants by the individual or designated representative including: (a) provider qualification verification, (b) employer-related activities including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, (c) Medicaid claims processing and reimbursement distribution, and (d) providing monthly accounting and expense reports to the consumer.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Category(s) *(check one or both)*:	☐	**Individual.** List types:	✓	**Agency.** List the types of agencies:

Provider Qualifications (*Provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Fiscal Management	Certified Public Accountant	Certified by DSPD as an authorized	Under state contract with DSPD as an authorized provider of services and

Agency	Section 58-26A, UCA, and R156-26A, UAC	provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA	supports to people with disabilities in accordance with 62A-5-103, UCA

Verification of Provider Qualifications	**Provider Type:**	**Entity Responsible:**	**Frequency**
	FMS	**DSPD**	**Annually**

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies)*:

☐	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *The limit or limits are specified in item C-4-a below.*
✓	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each participant. *The limit is based on the assignment of a prospective individual budget amount through the process that is specified in item C-4-b below.*
☐	**Budget Limits by Level**. Based on an assessment process, participants are assigned to funding levels or tiers that are subject to a limit on the maximum dollar amount of waiver services. *The process for assigning individuals to tiers or levels is specified in item C-4-c below.*
☐	**Other Limit.** *Limits on the amount of waiver services are determined through an alternate process that is specified in item C-4-d below.*
☐	**Not applicable.**

a. Limit(s) on Set(s) of Waiver Services. Specify the limit(s) on set(s) of services in the waiver and the policies that apply to the application of such limit(s):

b. Prospective Individual Budget Amount. Specify the process that the State employs to assign a prospective individual budget amount to a participant and the policies that apply to the application of the limit:

Utilizing the score derived from the Personal Assistance Critical Needs Assessment, the nurse case manager estimates the individual's prospective budget amount. During the annual service planning process, the participant's needs and available services are discussed with the individual. An individualized waiver services budget is agreed upon. The participant decides how the funds should be allocated among the waiver services.

If at any time the individual's service needs change or a health and safety issue arises, the participant contacts their case manager regarding these changes. If the participant requests an increase in their services they may petition in writing for a change. The administrative case manager will complete a new MDS-HC, Critical Needs Assessment and review the present care plan. These documents are presented to The DSPD Associate Director for review.

If additional funding is approved, the case manager notifies the participant; changes are made to the individual's service plan and the funding allocation plan to reflect the increase in funding. If the request is denied, the individual receives a Notice of Agency Action and information relating to their hearing rights.

c. Budget Limits by Level of Support. Specify the process that the State employs to assign participants to a funding level or tier and the policies that apply to the application of the budget limit:

d. Other Limit. Describe how the State establishes its limit and the policies that apply to the application of the limit:

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
✓	Case Manager (qualifications specified in Appendix C-3)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
✓	Other (*specify the individuals and their qualifications):*
	The waiver recipient.

b. Service Plan Development Safeguards. *Select one:*

✓	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to address the potential problems that may arise in this circumstance. *Specify*:

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Local Area Support Coordinator Liaison services provide the participant and/or family, legal representative with knowledge to identify the local community resources, available local waiver service providers and natural supports in order for the participant to make informed choices when multiple service options are available to fulfill the individualized care plan. Consumer Preparation services provide training to the participants to ensure they are prepared to recruit, supervise and direct their own personal assistance services to fulfill the individualized care plan.

The plan of care is developed by the recipient in consultation with the administrative case manager

and others as necessary and appropriate. The participant has the authority to specify who participates in their care planning process.

d. Service Plan Development Process and Scope. The service plan contains: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider who furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. Specify the process that is employed to develop the service plan and the scope of the plan. State laws, regulations, and policies cited that affect the service plan development process are available through the Medicaid agency or other operating agency (if applicable):

Based upon the standard comprehensive assessment process, the type of services and supports the participant needs to prevent institutionalization and assure his/her safety at home and/or a community-based setting are identified. The participant, in consultation with the administrative case manager, a plan of care is developed specifying the array of waiver and non-waiver services to be provided, and for each specified waiver service, the frequency, duration and provider of choice is identified.

e. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

During the preparation of the written care plan the participant will be informed in writing by the administrative case manager of waiver service options available to address the identified needs and expectations of the participant. Provider options are made available for each selected waiver service.

The individual will be given a choice of all waiver services and waiver service providers. The participant selects the service(s) and provider(s) of their choice(s) and it is listed on their plan of care.

f. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i).

The State Medicaid Agency retains the final authority for oversight of the care plan process. The oversight function involves an annual review of care plans for a sample of waiver participants representative of the caseload distribution across the program. In the event the sampling identifies potential systemic problems with plans of care, an expanded review would be initiated by the State Medicaid Agency.

g. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as needs change. Specify the minimum schedule for the review and update of the service plan:

○	Every three months or more frequently when necessary
○	Every six months or more frequently when necessary
○	Every twelve months or more frequently when necessary
✓	Other schedule (*specify*):

	The plan of care will be reviewed as frequently as necessary, with a formal review at least every 12 months, completed during the calendar month in which it is due. Should the recipient experience a significant change in his/her health status, the administrative case manager will initiate a review of the recipient's plan of care to assure appropriate services are defined to meet the recipient's care needs. The plan of care revisions will be completed in a time frame consistent with the nature of the change in status, but in no case will the time frame exceed 14 days from the date the administrative case manager was notified of the change in status. If the recipient was in an acute care facility, the plan of care will be reviewed within 7 days from the date the administrative case manager was notified that the recipient returned to his/her place of residence.

h. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

☐	Medicaid agency
✓	Operating agency
☐	Case manager
✓	Other (*specify):*
	The recipient

i. Fair Hearing. As specified in Appendix F, the State provides the opportunity for a Fair Hearing under 42 CFR Part 431, subpart E, to individuals who are denied the service(s) of their choice or provider(s) of their choice.

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring service plan implementation and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

This waiver maintains a consumer driven focus, as such the consumer has a responsibility to identify areas of concern, and report problems to his/her administrative case manager. A minimum of annually, the administrative case manager and consumer have a face-to-face visit. Additional contacts take place by phone on an as-needed basis.

The operating agency (DSPD) is responsible for designing and implementing a quality management program. This program includes procedures for overseeing the performance of the needs assessment process, service plan development and implementation process.

DSPD is responsible to organize the content and timeframes of its quality assurance program. Program performance reviews are to be done by DSPD staff who are not responsible for service planning and delivery to assess the accuracy and effectiveness of the link between the determination of need, the service plan, the implementation of case management services and the ongoing evaluation of progress towards the individual's stated goals.

At a minimum, an annual review will be conducted by DSPD utilizing an adequate sample to evaluate program performance.

All plans of care are subject to annual and periodic post-payment review and approval by the SMA. A sample of care plans will be reviewed each waiver year. Significant findings from those reviews will be reported to the operating agency. The operating agency will develop a plan of correction with specific timeframes for completion. The SMA will conduct follow-up reviews to ensure the plan of correction is implemented and sustained.

b. Monitoring Safeguards. *Select one:*

✓	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to address the potential problems that may arise in this circumstance. *Specify*:

Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences an especially strong commitment to participant direction. Indicate whether this waiver should be considered for Independence Plus designation (select one):

○	**Yes.** The State wants this waiver to be considered for Independence Plus designation.
✓	**No.** Independence Plus designation is not requested.

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction that are included in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that are involved in supporting individuals who direct their services; and, (d) other relevant information about the waiver's approach to participant direction.

Self-Administered Services means service delivery that is provided through a non-agency based provider. Under this method, individuals hire individual employees to perform personal assistance waiver services. The individual is then responsible to assure employee qualifications, hire, supervise, train, schedule, assure time sheet accuracy, etc. of the employee(s).

The self administered services method requires the use of a Financial Management Service to assist with managing employer-related financial responsibilities associated with self administered services.

The waiver participant has access to Consumer Preparation and Local Area Support Liaison services which provide the knowledge base for the individual to successfully direct their personal attendant services in their local area.

The participant has budget authority as it pertains to their personal assistance staff. The recipient decides how many employees they can afford to hire within the overall budgeted amount, the wages to be paid and the amount of hours worked. They are responsible to review all employee's timesheets for accuracy and submit them to the FMS agent for payment. The FMS agent sends the employer information after each pay period detailing what was paid and the amount remaining in their budget.

b. Participant-Direction Opportunities. Specify the participant-direction opportunities that are available in the waiver. *Select one:*

○	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over the workers who provide waiver services. Either the participant or an agency may function as the common law employer. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a

	budget.
✓	**Both Authorities.** The waiver provides both participant-direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

✓	Participant direction opportunities are available to participants who live in their own personal home or the home of a family member.
☐	Participant direction opportunities are available to individuals who reside in other living arrangements where fewer than four unrelated persons reside.
☐	The participant direction opportunities are available to persons in the following other participant living arrangements *(specify)*:

d. Election of Participant-Direction. Election of participant-direction is subject to the following policy (s*elect one):*

✓	The waiver serves only participants who direct their services.
○	Every participant (or the participant's representative) whose service plan includes participant-directed services may elect to direct some or all of their services as provided in the waiver. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participant direction opportunities are available only to participants whose service plan includes participant-directed services, elect to direct some or all their services and meet the following additional criteria specified by the State. *Specify the other criteria*:

e. Information Furnished to Participant. Specify: (a) the information about the participant direction opportunities (e.g., the benefits of participant-direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning electing participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided.

During the eligibility and enrollment process, the operating agency provides the individual with an orientation, including written materials, describing the self-administered services method. At that time it is explained to the individual that the personal assistance services component of the waiver utilizes the self-administered services model, the mandatory use of a qualified FMS agent, and the responsibilities of becoming an employer.

f. Participant Direction by a Representative. Specify the State's policy concerning participant direction by a representative *(select one)*:

○	The State does not provide for the direction of waiver services by a representative.
✓	The State provides for the direction of waiver services by representatives. Specify the representatives who may direct waiver services: *(check each that applies)*:

☐	Waiver services may be directed by legal representatives.
✓	Waiver services may be directed by an individual appointed by an adult participant. Specify policies that apply regarding the direction of waiver services by participant-appointed representatives:
	Individual's possessing decision making capability, but having communication deficits or Limited English Proficiency (LEP) may select a representative to communicate decisions on the individual's behalf.

g. Participant-Directed Services. Specify the participant-direction opportunity (or opportunities) available for each waiver participant-directed service specified in Appendix C-3. *(Check the opportunity or opportunities applicable for each service)*:

Waiver Service	Employer Authority	Budget Authority
PERS	☐	☐
Local Area Support Coordination Liaison	☐	☐
Consumer Preparation	☐	☐
Personal Attendant Services	✓	✓
FMS	☐	✓
	☐	☐

h. Financial Management Services. When the participant directs that payments be made directly to waiver providers, the State or another third-party entity must perform necessary financial transactions on behalf of the participant. Since financial management services are mandatory and integral to participant-direction, the State may not limit their availability. *Select one:*

✓	Financial Management Services are furnished through a third party entity. *(complete item E-1-h)*. Specify whether public or private entities furnish these services. *Select one:*	
	○	Governmental entities
	✓	Private entities
○	Financial Management Services are not furnished. Payments for waiver services are not made on behalf of the participant. Standard payment mechanisms are used. *Do not complete Item E-1-h*.	

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

✓	FMS are covered as the waiver service entitled	Financial Management Services
	in Appendix C-3.	
○	Financial Management Services are provided as an administrative activity. Provide the following information:	
	i.	Specify the types of entities that furnish financial management services and the method of procuring these services:
	ii.	Describe the scope of the services and participant supports that Financial Management Services entities provide *(check each that applies):*

		☐	Pay workers when the participant is the employer of record
		☐	Pay for waiver goods and services
		☐	Enter into provider agreements on behalf of Medicaid agency
		☐	Assure adherence to Federal and state laws and regulations (e.g., Labor, IRS)
		☐	Other services and supports *(specify)*:
	iii.	Specify the methods that are employed to (a) monitor and assess the performance of Financial Management Services entities, including ensuring the integrity of the financial transactions that they perform and (b) the entity (entities) responsible for such monitoring.	

j. Additional Supports for Participant Direction. In addition to financial management services, participant direction is facilitated when additional supports are available to assist participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Indicate how supports for participant direction supports are provided *(check each that applies)*:

☐	**Case Management Activity**. Some supports for participant directed are furnished as a case management activity by the individuals or entities specified in Appendix C. *Specify in detail the supports for participant direction furnished through case management:*
✓	**Waiver Service Coverage**. Some or all supports are provided through the waiver service coverage (e.g., supports brokerage) in Appendix C-3 entitled **Consumer Preparation Services**
✓	**Administrative Activity**. Some or all supports for participant direction are furnished as an administrative activity. *Specify the types of entities that furnish supports as an administrative activity and how services are procured, describe in detail the supports that they furnish, and the methods of evaluating performance of these entities:*
	Case Management

k. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate a participant's use of a participant direction opportunity and require the use of alternative service delivery methods, including how continuity of services and participant health and welfare is assured during the transition.

The Physical Disabilities Waiver supports only those individuals who are capable of directing their own services. Special circumstance disenrollments are cases that are non-routine in nature and involve circumstances that are specific to the individual involved. Examples of this type of disenrollment include the waiver participants no longer meets the corresponding institutional level of care requirements, the participants health and safety needs cannot be met by the current program's services and supports, or the participant has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate an individual support plan that meets minimal safety standards.

Special circumstance disenrollments require review and authorization prior to disenrollment to facilitate:

a. Appropriate movement amongst programs;

b. Effective utilization of program potential;

c. Effective discharge and transition planning;

d. Provision of information, affording participants the opportunity to exercise all rights; and

e. Program quality assurance/quality improvement measures.

The special circumstance disenrollment review process will consist of the following

activities:

a. The waiver support coordination agency recommending disenrollment will compile information to articulate the disenrollment rationale.

b. The waiver support coordination agency will then submit the information to the state-level program management staff for their review of the documentation of support coordination activities and of the disenrollment recommendation.

c. If state-level program management staff concurs with the support coordination recommendation, the case will be forwarded to the DHCF for a final decision.

d. The DHCF will review and assure the available array of Medicaid waiver and non-waiver services, and other available resources have been fully utilized to meet the individual's health and safety needs.

e. The DHCF will facilitate case staffing meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment.

f. The DHCF final disenrollment decision will be communicated to both the support coordination agency and the state-level program management staff in writing.

If the disenrollment is approved, the waiver support coordination agency will provide to the individual the required written notification of agency action and right to fair hearing information.

The support coordination agency will initiate discharge-planning activities sufficient to assure a smooth transition to an alternate Medicaid program or to other services.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The Physical Disabilities Waiver supports only those individuals that are capable of self-directing their own services. The Division of Health Care Financing (DHCF) in partnership with the Division of Services for People with Disabilities (DSPD) will compile information

on voluntary disenrollments, and routine involuntary disenrollments.

1. Voluntary disenrollments are cases in which participants choose to initiate disenrollment from the waiver. These cases require written notification to the Division of Health Care Financing by the Division of Services for People with Disabilities within 30 days from date of disenrollment. The Division of Services for People with Disabilities will maintain documentation detailing the discharge planning activities completed with the waiver enrollee as part of the disenrollment process.

2. Pre-Approved involuntary disenrollments are cases in which participants are involuntarily disenrolled from a home and community based waiver program for any one or more of the specific reasons listed below:

    a. Participant death;

    b. Participant no longer meets financial requirement for Medicaid program eligibility;

    c. Participant has moved out of the State of Utah; or

    d. Participant whereabouts are unknown.

Pre-Approved involuntary disenrollments require written notification to the Division of Health Care Financing by the Division of Services for People with Disabilities within 30 days from date of disenrollment. No Division of Health Care Financing prior review or approval of the decision to disenroll is required. The Division of Services for People with Disabilities will maintain documentation detailing the discharge planning activities completed with the waiver enrollee as part of the disenrollment process.

m. Estimated Utilization of Participant-Direction Opportunities. In the following table, estimate for the final year that the waiver will be in effect the unduplicated number of participants who are expected to utilize each applicable participant-direction opportunity and the percentage this number represents of the total number of waiver participants.

Table E-1-l

Employer Authority		Budget Authority/ Budget + Employer Authority	
Number of Participants	% of All Participants	Number of Participants	% of All Participants
135	100	135	100

Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Check each that applies:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (employer of fact) of workers who provide waiver services. An agency is the common law employer (employer of record) of participant-selected staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:
✓	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer (employer of record) of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent serves as the participant's agent in conducting payroll and other employer responsibilities that are required by Federal and State law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Check the decision making authorities that participants exercise*:

✓	Recruit staff
✓	Refer staff to agency for hiring (co-employer)
☐	Select staff from worker registry
✓	Hire staff
☐	Refer staff to employer agent
✓	Verify staff qualifications
✓	Obtain criminal history and/or background investigation of staff. Specify the state's policies regarding how the costs of such investigations are addressed:
	The operating agency (DSPD) is responsible to pay any fees associated with background investigations.
✓	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
✓	Determine staff duties consistent with the service specifications in Appendix C-3.
✓	Determine staff wages and benefits
✓	Schedule staff
✓	Instruct and train staff in duties
✓	Supervise staff
✓	Evaluate staff performance

✓	Verify time worked by staff and approve time sheets
✓	Discharge staff or notify the co-employer of the need for substitute staff
☐	Other *(specify)*:

b. Participant – Budget Authority

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply*:

☐	Reallocate funds among services included in the budget
✓	Determine the amount paid for services
✓	Substitute service providers
✓	Schedule the provision of services
✓	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
✓	Specify how services are provided, consistent with the service specifications contained in Appendix C-4
✓	Identify service providers and refer for provider enrollment
☐	Authorize payment for waiver goods and services
✓	Review and approve provider invoices for services rendered
☐	Other *(specify):*

ii. Method of Budget Determination. Describe in detail the method(s) that are used to establish the amount of the budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these budget determination method(s) must be made publicly available.

Utilizing the score derived from the Personal Assistance Critical Needs Assessment, the administrative case manager estimates the individual's prospective budget amount. During the annual service planning process, the participant's needs and available services are discussed with the individual. An individualized waiver services budget is agreed upon. The participant, in collaboration with the Administrative Case Manager, decides how the funds should be allocated among the waiver services to assure the health and safety of the participant.

iii. Informing Participant of Budget Amount. Describe the process by which the State informs each participant of the budget amount and the procedures by which the participant may request an adjustment in the budget amount. In accordance with the procedures specified in Appendix F, the participant is offered the opportunity to request a Fair Hearing when the participant's request for an adjustment to the budget is denied or the amount of the budget is reduced.

If at any time the individual's service needs change or a health and safety issue arises, the participant is responsible to contact their administrative case manager with these changes. If the participant requests an increase in their services they may petition in writing for a additional funds. The administrative case manager will complete a new MDS-HC, Critical Needs Assessment and review the present care plan. These documents are presented to the DSPD Associate Director for review.

If additional funding is approved, the case manager notifies the participant, changes are made to the individual's service plan and the funding allocation plan. If the request is denied, the

individual receives a Notice of Agency Action and information relating to their hearing rights.

iv. Participant Exercise of Service Plan/Budget Flexibility. *Select one:*

○	The participant has flexibility to manage the budget and services included in the budget without modification to the service plan *(Complete Item E-2-b-v)*.
✓	Modifications to the participant budget must be incorporated in the service plan *(Do not complete Item E-2-b-v)*.

v. Review and Documentation of Budget Changes. Specify the procedures for changing the distribution of funds in the approved budget and how changes are documented. Specify the circumstances (if any) when participant-initiated changes to the distribution of funds within the total authorized budget amount must be reviewed and authorized before they take effect and the entity responsible for authorizing such changes.

When a participant wants to change the distribution of funds in their budget they contact the administrative case manager. The participant and the case manager discuss the desired changes and come to an agreement about the revised budget. The case manager updates the care plan and the individual's budget. Copies of both documents are given to the consumer. A copy of the revised budget is sent to the FMS provider.

vi. Expenditure Safeguards. Describe the safeguards that have been established for preventing the premature depletion of the participant budget or address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for ensuring the implementation of these safeguards:

Each month the administrative case manager reviews the billing statement from the FMS provider and a monthly budget sheet from the operating agency's financial analyst. If these documents reveal over/under utilization the case manager contacts the participant to discuss the reasons why and revise the budget if necessary. Additionally, a three year trend report is generated for each participant. The administrative case manager and the participant go over this report annually to identify trends in utilization/expenditures in order to have the most accurate budget possible.

Appendix F: Participant-Rights

Appendix F-1: Opportunity to Request a Fair Hearing

a. Opportunity for Fair Hearing. The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item I-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated.

b. Method for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. State laws, regulations, and policies referenced in the description are available through the operating or Medicaid agency.

1. DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

An individual and the individual's legal representative will receive a written Notice of Agency Action from the waiver support coordinator if the individual is not given the choice of home and community-based services or institutional care, or who is denied the waiver service(s) of their choice, or the provider(s) of their choice, or who is found ineligible for the waiver program.

The Notice of Agency Action delineates the individual's right to appeal the decision. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions, but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing (Form 490S) and directing the request be sent to the Department of Health, Division of Health Care Financing for a formal hearing and determination.

The waiver care plan serves as the formal document identifying services that the waiver enrollee receives based on the comprehensive needs assessment. At the time a substantial change in a waiver enrollee's condition results in a change in the person's assessed needs, the individual support plan is revised to reflect the types and levels of service necessary to address the current needs. If the revisions to the individual support plan result in termination of a covered waiver service, reduction in the waiver services being received, or denial of services that the individual feels are necessary to prevent institutionalization, the individual or legal representative has the right to appeal the decision to revise the individual support plan. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions, but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing (Form 490S) and directing the request be sent to the Department of Health, Division of Health Care Financing for a formal hearing and determination.

2. SINGLE STATE AGENCY

The State Medicaid Agency provides individuals applying for or receiving waiver services an opportunity for a hearing upon written request (see A.1. above), if they are:

a. Not given the choice of institutional (NF) care or community-based (waiver) services;

b. Denied the waiver provider(s) of their choice if more than one provider is available to render the service(s);

c. Denied access to waiver services identified as necessary to prevent institutionalization; or

d. Experience a reduction, suspension, or termination in waiver services identified as necessary to prevent institutionalization.

It is the policy and preference of the single State agency to resolve disputes at the lowest level through open discussion and negotiation between the involved parties.

DIVISION OF HEALTH CARE FINANCING
ADMINISTRATIVE HEARING PROCEDURES

All hearings before the Division of Health Care Financing except as otherwise set forth shall be conducted as a formal hearing.

Advance Notice

1. Each individual who is affected by an adverse action taken by DHCF or its administrative Fiscal Agent will be given advance notice of such action:

2. A notice must contain:

    a. A statement of the action DHCF or its administrative Fiscal Agent intends to take;
    b. The date the intended action takes effect;
    c. The reasons for the intended action;
    d. The aggrieved person's right to request a formal hearing before DHCF, when applicable, and the method by which such hearing may be obtained from DHCF;
    e. A statement that the aggrieved person may represent himself or use legal counsel, relative, friend, or other spokesman at the formal hearing; and,
    f. An explanation of the circumstances under which Medicaid coverage or reimbursement will be continued if a formal hearing is timely requested.
    g. DHCF will mail an advance notice at least ten calendar days before the date of the intended action.

Request for Formal Hearing

1. An aggrieved Medicaid applicant/recipient/provider may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later, by DHCF of an action or inaction.

2. Failure to submit a timely request for a formal hearing will constitute a waiver of a person's formal hearing or pre-hearing rights. A request for a hearing shall be in writing, shall be dated, and shall explain the reasons for which the hearing is requested.

3. The address for submitting a "Request for Hearing/Agency Action" is as follows:

Utah Department of Health
Division of Health Care Financing
Director's Office/ Formal Hearings
P.O. Box 31431
Salt Lake City, UT 84131-9988

Reinstatement/Continuation of Services

1. DHCF may reinstate services for recipients or suspend any adverse action for recipients/providers if an aggrieved person requests a formal hearing not more than ten (10) calendar days after the date of action.

2. DHCF must reinstate or continue services for recipients or suspend adverse actions for providers until a decision is rendered after a formal hearing if:

    a. Adverse action is taken without giving the ten-day advanced mailed notice to a recipient/provider in all circumstances where such advance notice is required;

    b. In those circumstances where advance notice is not required, the aggrieved person requests a formal hearing within ten calendar days following the date the adverse action notice is mailed; or

    c. DHCF determines that the action resulted from other than the application of federal or state law or policy.

c. Notice(s). Appendix #1 to Appendix F-2 contains the notice(s) that are used to offer individuals the opportunity for a Fair Hearing.

Appendix F-2: Additional Dispute Resolution Mechanism

a. Availability of Additional Dispute Resolution Mechanism. Indicate whether the State operates another dispute resolution mechanism that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

✓	The State operates an additional dispute resolution mechanism *(complete Item b)*
○	Not applicable (*do not complete Item b)*

b. Description of Additional Dispute Resolution Mechanism. Describe the State's additional dispute resolution mechanism, including: (a) the State agency that operates the mechanism; (b) the nature of the mechanism (i.e., procedures and timeframes), including the types of disputes addressed through the mechanism; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the mechanism: State laws, regulations, and policies referenced in the description are available through the operating or Medicaid agency.

The Department of Human Services has an informal hearings process and the Division of People with Disabilities has an informal dispute resolution process. The informal dispute resolution process is designed to respond to a participant's concerns without unnecessary formality. The dispute resolution process is not intended to limit a participant's access to formal hearing procedures; the participant may file a Request for Hearing any time in the first 30 days after receiving Notice of Agency Action.

When DSPD receives a Hearing Request Form (490S) a three step resolution process begins with:

1. The Division staff explain the regulations on which the action is based and attempt to resolve the disagreement.
2. If resolution is not yet reached, Division staff arranges a Region Review meeting between the individual and/or their legal representative and the Region Supervisor and/or the Region Director.
3. If the Region Review process is unsuccessful, Division staff arrange a Division Review meeting between the individual and/or their legal guardian and the Division Director and Region Director.

If the three step resolution process is not able to resolve the problem, the individual may request an informal hearing with a hearing officer with the Department of Human Services Office of Administrative Hearings.

This informal hearing reviews the information DSPD used to make a decision or take an action as well as review information from the participant and/or their legal representative demonstrating why the decision or action is not correct.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

✓	**Yes.** The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver.
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

b. Operational Responsibility. Specify the State agency responsible for the operation of the grievance/complaint system:

Utah Department of Human Services, Division of People with Disabilities and Utah Department of Health, Division of Health Care Financing, Long Term Care Bureau

c. Description of System. Describe the grievance/complaint system, including (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available through the operating or Medicaid agency.

DSPD Policy 1.11 Conflict Resolution requires the case manager to provide information to recipients on the conflict resolution process and on how to contact the case manager's supervisor. The supervisor reviews all complaints submitted either orally or written and any relevant information submitted with the complaint. The supervisor will take appropriate action to resolve the dispute and respond to all parties concerned. If the parties are unable to resolve the dispute either party may appeal to the Region Director. The Region Director will meet with the parties and review any evidence presented. The Region Director shall determine the best solution for the dispute. The Region Director will prepare a concise written summary of the finding and decision and send it to the parties involved. Either party may request an independent review of they do not agree with the Region Director's decision. Based on interviews with the parties and a review of the evidence, the independent reviewer will prepare for the Division Director a written summary of the factual findings and recommendations. Based on the independent reviewers report the Division Director will determine the appropriate resolution for the dispute and shall implement any necessary corrective action.

Waiver recipients may also file a written or verbal complaint/grievance with the Dept. of Human Services Ombudsman. This Ombudsman is specifically assigned to the Operating Agency, although operates independent of them. When the Ombudsman receives a complaint there is an investigation involving all pertinent parties. The Ombudsman then works with the parties to come to a resolution.

Both the Dept. of Human Services and the Dept. of Health have constituent services available. Participants may call and verbally register a complaint/grievance. The constituent services representative ensures the caller is referred to the appropriate party for problem resolution. The constituent services representative follows up with both parties within 5 days to ensure resolution.

Long Term Care Bureau (LTCB) staff members receive complaints/grievances. Recipients may file a written or verbal complaint; it is logged into a data base. An investigation is conducted with all pertinent parties involved. The staff member(s) reviews the waiver implementation plan and applicable rule/policy/procedure. A decision is communicated in writing to the appropriate parties and if indicated, information about the right to a hearing is included.

Attachment #1 to Appendix F-1

Utah DHS-DSPD
4/03

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

NOTICE OF AGENCY ACTION

Page 1 of 1

Form 522-F PD

Services funded by Medicaid waiver: Applicant/Recipient is entitled to a FORMAL HEARING

Mailing Date: _____ Agency File No.:_____

Applicant:_____

Legal Guardian (if any)_____

Address: _____

Dear _____:

In accordance with the Utah Administrative Procedures Act (Title 63, Chapter 46b of the Utah Code) and the rules of the Utah Department of Human Services, the Division of Services for People with Disabilities (the "Division") hereby gives notice that it is taking the following action with respect to your application or the services you receive:

☐ Approve ☐ Deny ☐ Increase ☐ Reduce ☐ Place on Waiting List ☐ Other (*specify*)_____

_____

This action is based upon the following facts: _____

_____

Title 62A, Chapter 5 of the Utah Code and the following policy authorize this action and give the Division jurisdiction: (cite policy).

You have the right to appeal this decision. Under Rule R410-14-5 of the administrative hearing procedures for the Department of Health, Division of Health Care Financing, you may request a formal hearing if you file your request on time and if there is a disputed issue of fact. Formal hearings are governed by Sections 63-46b-6 to -11 of the Utah Code. If you need help in preparing your appeal, you may call our office at (_____)_____

You do not have to appeal if you do not want to. If you wish to appeal, however, you must send us a written hearing request within 30 days of the postmark date for this notice. If you wish your services or benefits to continue during the resolution/hearing process, your hearing request must be filed within 15 days of the postmark of this notice. If your request is not received within 15 days, you will not be eligible for continued benefits. If you fail to file a hearing request or to attend a scheduled hearing, you may lose your right to challenge the agency action or you may be held in default.

If this notice indicates above that you are eligible to receive Medicaid waiver support services, you are also eligible to receive services in a Skilled Nursing Facility. Please contact your nurse coordinator for more information.

Sincerely,

Name	Title	cc:
Signature	Date	

Utah-DSPD **YOUR HEARING RIGHTS** FORM 490S (7/99)

Your Right to a Formal Hearing. If you or your legal representative disagree with a decision, service, or action of the Utah Division of Services for People with Disabilities ("Division"), you have the right to challenge the Division's action at a formal administrative hearing. If you so choose, you may also use a three-step informal resolution process (outlined below) to try to resolve your complaint before the formal hearing or instead of the formal hearing. By choosing the informal resolution process, however, you do *not* lose your right to a formal hearing. If you fill out this Hearing Request form and submit it to the address listed below, the Division will forward your request to the appropriate administrative hearing office(s) so that your right to a formal hearing is preserved, even if you choose to use the informal process first. Of course, you also have the right to refuse the formal hearing, if that's what you wish.

The Division's 3-Step Informal Resolution Process.

STEP 1 You may meet with the Region support coordinator, who will explain the legal basis for the Division's action and attempt to address your concern.
STEP 2 If Step 1 does not resolve the issue, you may meet with the Region supervisor and/or the Region director to discuss your concern.
STEP 3 If Step 2 does not resolve the issue, you may meet with the Division director to discuss your concern.

Your Right to Be Represented by Your Parents, Legal Guardian or Attorney. You may have your parents, your legal guardian and a support person accompany you to the Division's informal resolution meetings and the Department's formal hearing. You may want to consult your support coordinator at the Division about whether you might be eligible for free legal help. It should be noted, however, that your attorney represents *you*, and not your parents or your legal representative.

If you want a formal hearing or if you want to use the informal resolution process, please complete the bottom half of this sheet and sign it. Detach and mail to:

[NAME/ADDRESS OF REGION DESIGNEE HERE].

✂----------

HEARING REQUEST FORM

Choose one: ❒ **I want a formal hearing but I do *not* want to use the informal resolution process.**
❒ **I want *both* a formal hearing *and* the informal resolution process.**
❒ **I want the informal resolution process only. I do *not* want a formal hearing.**

Do you want your services continued during the resolution/hearing process? ❒ Yes ❒ No
If you choose "yes," you must file this form within 15 days of the postmark date on the enclosed Notice of Agency Action. Otherwise, the deadline is 30 days from the postmark date.

I am requesting a resolution/hearing because _____

Name:	**Street Address**	**Date of Request**
Social Security Number	**City, State, Zip**	**Daytime Phone**
Signature(s) of Person and/or Representative Filing This Hearing Request		

REQUEST FOR HEARING/AGENCY ACTION

NAME OF PROVIDER/PATIENT OR CLIENT/APPLICANT REQUESTING HEARING:

NAME: _____

ADDRESS: _____

_____

Social Security Number: ____/____/____ Client I.D. or Provider # (if known)_____

1. The relief or action sought from the agency (the reason you are requesting a hearing) is: _____

_____

_____

2. The facts and reasons forming the basis for relief of agency action (the reasons you believe you are entitled to a hearing) are: _____

_____

_____

3. The names and addresses of all persons to whom you are sending a copy of this request for a hearing:

Name: _____ Address: _____

_____

Name: _____ Address: _____

_____

Name: _____ Address: _____

_____

PLEASE ENCLOSE A COPY OF THE DENIAL NOTICE THAT CAUSED YOU TO REQUEST THIS HEARING. THIS IS VERY IMPORTANT. WITHOUT THIS INFORMATION YOUR HEARING COULD BE DELAYED.

THIS REQUEST MUST BE FILED WITH THE DIRECTOR'S OFFICE/FORMAL HEARINGS, DIVISION OF HEALTH CARE FINANCING WITHIN ____ DAYS OF THE DATE A DENIAL NOTICE IS ISSUED. (90 days for financial eligibility, 30 days for provider requests and anything other than financial eligibility.) A COPY OF THIS REQUEST MUST BE MAILED TO EACH PERSON KNOWN TO HAVE A DIRECT INTEREST IN THE REQUESTED AGENCY ACTION.

IF YOU WILL BE REPRESENTED BY AN ATTORNEY, THE ATTORNEY MUST FILE A NOTICE OF APPEARANCE IMMEDIATELY. If the Division of Health Care Financing does not receive notice at least ten calendar days before any scheduled hearing that an attorney for the petitioner will be present, the hearing may be rescheduled.

Attorney Representation? YES NO (circle)
NAME OF ATTORNEY/REPRESENTATIVE _____

ADDRESS: _____

_____

_____ _____ _____
Signature of person requesting hearing Phone # Date

SEND REQUEST TO: DIRECTOR'S OFFICE/FORMAL HEARINGS
DIVISION OF HEALTH CARE FINANCING
288 NORTH 1460 WEST
P.O. BOX 143105
SALT LAKE CITY UT 84114-3105

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and timelines for reporting. State laws, regulations, and policies referenced in this specification are available through the Medicaid agency or the operating agency (if applicable).

R539-5-6 requires the individual/ their representative or a provider agency to report to the administrative case manager if at any time the participant's health and/or safety is jeopardized. Such instances may include, but are not limited to:
1. Actual or suspected incidents of abuse, neglect, exploitation or maltreatment per the DHS/DSPD Code of Conduct and Utah Code Annotated Sections 62-A-3-301 through 321 (mandatory reporting to Adult Protective Services)
2. Drug or alcohol misuse
3. Medication overdose or error requiring medical intervention
4. Missing person
5. Evidence of a seizure in person with no seizure diagnosis
6. Significant property destruction ($500.00 or more)
7. Physical injury requiring medical intervention
8. Law enforcement involvement

Incidents that require reporting may be done verbally and must be made within 24 hours. Within 5 days the person reporting the incident completes the DSPD Form 1-8. If the person reporting is unable to complete the DSPD Form 1-8, accommodations are made and the administrative case manager writes the report.

The administrative case manager reviews the information, develops and implements a follow-up plan, as appropriate. The form and any follow-up conducted are filed in the individual's case record.

b. Participant Training and Education. Describe how training and/or information is provided to participants concerning protections from abuse, neglect, and exploitation and how participants can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Consumer Preparation Services provides the participant with information/training on the following topics: (a) how to avoid theft/security issues; (b) maintaining personal safety when recruiting/interviewing potential employees; (c) assertiveness/boundaries/rules with employees; (d) maintaining personal safety when firing an employee; (e) when and how to contact and report instances of abuse, neglect, exploitation; (f) resources on a local level to assist the participant if they are a victim of abuse, neglect or exploitation

c. **Responsibility for Review of and Response to Critical Events or Incidents**. Specify the entity (or entities) that receives reports of each type of critical event or incident specified in item G-1-a, the methods that are employed to evaluate reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The operating agency has the responsibility of receiving, reviewing and responding to critical incident reports. Within five days of the incident the administrative case manager evaluates the information contained in the incident report and determines if further investigation or follow-up is warranted. If the incident involves allegations or actual abuse, neglect, exploitation or maltreatment the operating agency is responsible to ensure timely notification is made to either Adult Protective Services or the police.

d. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants.

The operating agency is responsible to ensure proper reporting and response to critical incidents. DSPD maintains a database of all critical incident reports. The information contained in the database is analyzed and trends are identified. A critical incident summary report is generated annually and given to the LTCB.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

This Appendix must be completed when state policy permits the use of restraints and/or restrictive interventions during the course of the provision of waiver services regardless of setting.

a. Applicability. Select one:

✓	This Appendix is not applicable. The State does not permit the use of restraints or restrictive interventions *(do not complete the remaining items)*
○	This Appendix applies. *Check each that applies:*
☐	The use of personal restraints, drugs used as restraints, mechanical restraints and/or seclusion is permitted subject to State safeguards concerning their use. *Complete item G-2-b.*
☐	Service furnished to waiver participants may include the use of restrictive interventions subject to State safeguards concerning their use. *Complete items G-2-c.*

b. Safeguards Concerning Use of Restraints or Seclusion

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed:

c. Safeguards Concerning the Use of Restrictive Interventions

i. Safeguards concerning the use of restrictive interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to individuals, locations or activities, or restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted.

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does need not be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○	**Yes**. This Appendix applies *(complete the remaining items)*.
✓	**No**. This Appendix is not applicable *(do not complete the remaining items)*.

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

○	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*
○	Not applicable. (*do not complete the remaining items*)

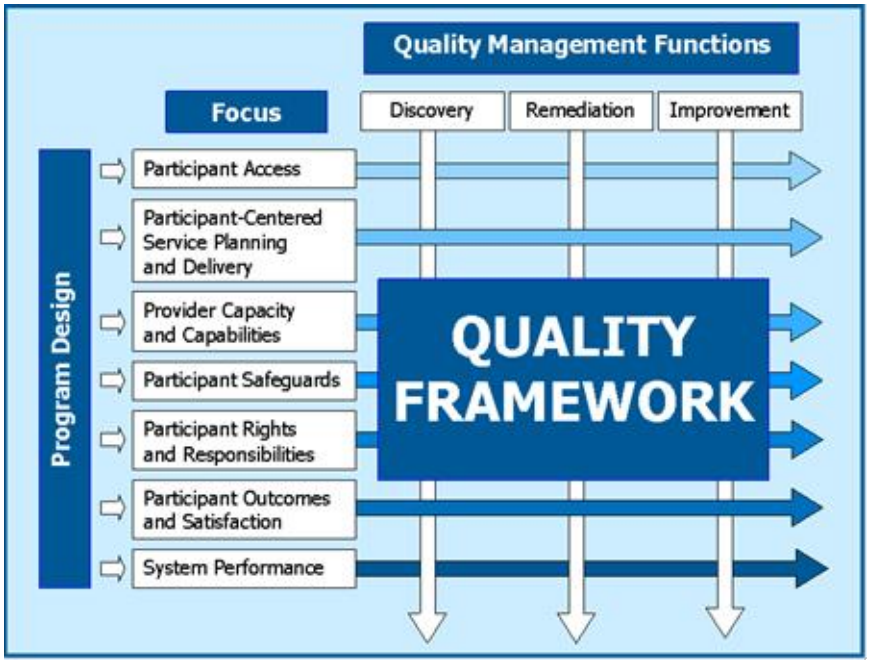
ii. State Policy. Summarize the State policy that applies to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

○	Providers that are responsible for the administration of medications to waiver participants are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	a) Specify State agency (or agencies) to which errors are reported:
	b) Specify the types of medication errors that providers are required to *record:*
	c) Specify the types of medication errors that providers must *report* to the State:
○	Providers responsible for the administration of medications to waiver participants are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed.

Appendix H: Quality Management Strategy



Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operation. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. A Quality Management Strategy is explicit about the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will go beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting the waiver assurances articulated in 42 CFR §441.301 and §441.302.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H.

The Quality Management Strategy must describe how the state will determine that each waiver assurance is met. The description must include:

- Activities or processes related to discovery i.e. monitoring and recording the findings. *
- Roles and responsibilities of those involved in measuring performance and making improvements. Include administrative entities identified in Appendix A, and individuals, advocates, providers, etc.
- The sources of data used to measure performance.
- The frequency with which performance is measured.

  * Descriptions of monitoring/over sight activities that occur at the individual and provider level of service delivery have been provided in the application in Appendices B, C, D, G, and I. These monitoring activities provide a foundation for QM by generating information that can be aggregated and analyzed to measure the overall performance of the system. The description of the QM Strategy does not have to repeat those descriptions provided in other parts of the waiver application.

The Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement

The Quality Management Strategy must describe how the state compiles quality management information and communicates this information (in report or other forms) to participants, families, waiver providers, other interested parties, and the public, including the frequency of dissemination.

The Quality Management Strategy must include periodic evaluation and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy.

If the State's Quality Management Strategy strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

Introduction

Introduction:
The purpose of the Quality Management Strategy is to evaluate, improve and enhance the quality of services provided to consumers of the HCBS Medicaid Waiver for Persons with Physical Disabilities. It includes processes to assess the Waiver for program compliance with federal and state standards and assurances and methods for remediation and improvement. The Strategy is a multi level approach to quality assurance and quality improvement of the Physical Disabilities (PD) Waiver. TheLong Term Care Bureau (LTCB) has administrative authority over the PD Waiver. The Division of People with Disabilities is the waiver operating agency. DSPD conducts quality assurance activities to assure compliance with the assurances in the PD Waiver State Implementation Plan.

Part I. Assurances, describes the quality assurance activities that are conducted for each of the federal assurances. *Part II. Reports*, identifies the types of reports that will be generated and the distribution of these reports. *Part III. Evaluation and Revision* of the Quality Management Strategy describes the plan for periodically reviewing and revising the quality management strategy.

Part I. Assurances

This section addresses the quality assurance activities that are conducted for each of the Assurances in the State Implementation Plan by the waiver operating agency. It also describes activities of the LTCB with respect to evaluating the effectiveness of these quality assurance and quality improvement activities. Included in this section are the **processes** that address compliance of each assurance, the current activities that are utilized for **discovery (including monitoring, data collection and analysis)** and **remediation/improvement** strategies.

Level of Care
Process: The waiver operating agency RN case managers employed by DSPD completes an assessment and Level of Care (LOC) determination for each PD Waiver participant.
Discovery: The DSPD Quality Management Unit conducts an annual Internal Quality Assurance Review. They review a representative sample of case records to determine the accuracy of LOC determinations. A report of the results of the internal review will be completed and submitted to the Division's Associate Director who then reviews it with the administrative case managers.
Remediation/Improvement: If the findings of the DSPD Quality Management Unit report indicate a negative finding a corrective action plan is developed and implemented. If ongoing or annual reviews conducted by the BLTC reveal a trend in inaccurate level of care determinations, the LTCB will require the DSPD to provide plans of correction within specific time frames to correct the problems. The LTCB will conduct follow up activities to assure that corrections are sustaining.

Individual Plans of Care
Process: Assessments and re-assessments are conducted by the waiver operating agency.

Participants are provided a "Provider Choice Form" by the waiver operating agency to assist them in obtaining information about and selecting from qualified providers. The case managers and Local Area Support Liaisons assist participants to find out more information about individual providers. There is an annual review of the individual plan of care; case managers monitor participants by phone and through contact with the Independent Living Centers to assess the effectiveness and adequacy of services. The Local Area Support Liaison at the ILC submits an activity log and a monthly summary with the billing each month to the case manager. These documents keep the administrative case manager informed about the individual's progress towards reaching their objectives in the plan of care. Case managers make revisions to care plans as needed based on ongoing and annual assessments.

Discovery: The DSPD Quality Management Unit conducts an annual Internal Quality Assurance Review. They review a representative sample of case records to determine if plans of care match the assessed needs, are adequate in scope, duration and frequency of services provided and are being implemented. Annually, the case managers conduct a satisfaction survey to determine if the participant is satisfied with the program. In addition, the LTCB reviews plans of care during its annual review of the PD Waiver.

Remediation/Improvement: If the findings of the DSPD Quality Management Unit report indicate a negative finding a corrective action plan is developed and implemented. If the results of the annual participant survey reveals areas where the program could improve a strategy is developed to address the participants' concerns and corrective action is implemented. If ongoing or annual reviews conducted by the LTCB reveal a trend in unacceptable plans of care, the LTCB will require the DSPD to provide plans to correction within specific time frames to correct the problems. The LTCB will conduct follow up activities to assure that corrections are sustaining.

Qualified Providers

Process: All providers must have a Medicaid provider agreement with the Department of Health except in the case of personal attendants employed directly by waiver clients. In that case, the Financial Management Services agent must have a completed copy of the employer agreement in the employment record of each personal attendant. In addition, providers of health care to vulnerable adults are subject to criminal background checks and abuse registry screening.

Discovery: Annually, the case managers conduct a satisfaction survey to determine if the participant is satisfied with the program. If the results of the annual participant survey reveal areas where the program could improve a strategy is developed to address the participants' concerns and corrective action is implemented. The LTCB conducts annual reviews of the PD Waiver including interviews with participants regarding provider performance. The LTCB reviews the Freedom of Choice documents to assure the participant had a choice between HCBS or institutional services and that they were given information about qualified providers from which to choose services. The LTCB contacts DSPD with issues or concerns related to choice, providers or the participants that are receiving services from them.

Remediation/Improvement: If ongoing or annual reviews conducted by the LTCB reveal unacceptable performance by providers, the LTCB will require the DSPD to provide plans of correction within specific time frames to correct the problems. The LTCB will conduct follow up activities to assure that corrections are sustaining.

Health and Welfare

Process: Case managers and/or Local Area Support Liaisons will report suspected incidents of abuse, neglect and exploitation of an adult to the Adult Protective Services (APS) unit of the

Division of Aging and Adult Services (DAAS). Case managers and/or Local Area Support Liaisons work closely with local APS workers to resolve these issues. When concerns regarding health and welfare do not rise to the level that APS can intervene, the case managers and the Local Independent Living Center's Support Liaison put additional safeguards in place, whenever possible. At each contact between the case manager and the participant, the case manager strongly encourages the use of smoke and carbon monoxide detectors, fire extinguishers and an emergency kit.

Discovery: Through ongoing and annual assessments, communication with participants and the Independent Living Centers, DSPD will monitor the health and safety of the individual. During annual reviews the LTCB will conduct interviews with participants, their families and providers to assure that participants' health and welfare needs have been identified and addressed.

Remediation/Improvement: If annual reviews conducted by the BLTC reveal a trend in health and welfare issues, the BLTC will require the DSPD to provide plans of correction within specific time frames to correct the problems. If abuse, neglect and/or exploitation of an individual is identified during the annual review, the BLTC will contact DSPD for immediate correction and, when appropriate, make a referral to APS. The BLTC will conduct follow up activities to assure that corrections are sustaining.

Administrative Authority

Discovery: The DSPD Quality Management Unit conducts an annual Internal Quality Assurance Review. A thorough review of the component parts of the PD Waiver is conducted along with a review of the financial processes and provider claims. Results of the findings and plans of correction, if any, are sent to the LTCB. The LTCB reviews each report and requests additional information or follow up when necessary. The LTCB conducts an annual review of the PD Waiver Program. The type of review will be determined based an analysis of several sources: issues identified in the DSPD Quality Management Unit annual report, issues identified in the previous year's LTCB Annual Review, focus areas selected by the LTCB, issues identified in the annual participant survey. A plan will be developed each year that identifies the sample criteria. An annual review will not be conducted during a year that the Waiver Program is reviewed by CMS.

Financial Accountability

Process: The administrative case manager reviews each participants monthly billing statements from the financial management agent and a monthly budget sheet generated by the DSPD Financial Analyst.

Discovery: Annually the DSPD Fiscal Review and Audit Unit reviews a sample of payment histories and the documentation to support those payments to assure that the providers have billed only for services that have been authorized and that the rate billed is correct. The sample includes information from all of the contract providers and individuals who are self-directing their own programs. Post-payment reviews are conducted by the Medicaid agency. This includes reviews a sample of individual written support plans and Medicaid claims histories to ensure: (1) all of the services required by the individual are identified in the support plan, (2) that the individual is receiving the services identified in the support plan, and (3) that Medicaid reimbursement is not claimed for waiver services which were not included in the support plan.

Remediation: When DSPD or the LTCB determine billing errors, providers are required to make corrections.

Part II. Reports

DSPD prepares reports of their monitoring audits and when necessary generate a corrective action plan. All corrective actions have time frames for a response. Follow-up is done on all corrective action. Copies of all reports are sent to the LTCB. The LTCB distributes the findings of its annual report to the Medicaid Director and DSPD.

Quality Improvement Initiative: The LTCB will develop a protocol regarding the distribution of reports to additional appropriate entities.

Part III. Evaluation and Revision of the Strategy

The Physical Disabilities Waiver Quality Management Strategy is a dynamic document. It is designed to reflect innovations, modifications and current trends with respect to home and community based services long term care programs. Hence, the areas of emphasis for each fiscal year review of the Physical Disabilities Waiver may change at any time based on additional information from any source that may play a part in the waiver's development and implementation. At least annually the Quality Management Plan will be reviewed for its effectiveness to meet the assurances, sustain corrections, and determine quality improvement initiatives.

Appendix I: Financial Accountability

Applicable Statutory Requirements

a. Direct payment. In accordance with §1902(a)(32) of the Act, payments for waiver services are made by the Medicaid agency directly to the providers of waiver and State plan services.

b. Provider agreement. In accordance with §1902(a)(27) of the Act, there must be a provider agreement between the Medicaid agency and each provider of services under the waiver.

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that the State employs to ensure the integrity of payments made for waiver services, including: (a) State requirements concerning the independent audit of provider agencies; (b) the State's own financial audit program to ensure the integrity of provider claims for Medicaid payment of waiver services, including the methods, scope and frequency of audits conducted by the State; and, (c) the State agency (or agencies) responsible for conducting the State financial audit program. State laws, regulations, and policies referenced in the description are available through the Medicaid agency or the other waiver operating agency (if applicable).

The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted. The State conducts a single audit in conformance with the Single Audit Act of 1984, Public Law 98-502.

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES ROLE AND PROVIDER CONTRACTING REQUIREMENT

The Division of Services for People with Disabilities (DSPD) is the designated State Agency responsible for planning and developing an array of services and supports for persons with disabilities living in Utah. State statute 62A-5-103, 1953 as amended, sets forth DSPD's authority and responsibility to:

1. Plan, develop and manage an array of services and supports for individuals with disabilities;
2. Contract for services and supports for persons with disabilities;
3. Approve and monitor and conduct certification reviews of approved providers;
4. Act as a Fiscal Agent to receive and disburse funds; and
5. Develop standards and rules for the administration and operation of programs operated by or under contract with the division.

In accordance with DSPD's lead role and designated responsibilities, monies allocated for services for persons with disabilities are appropriated by the State Legislature to DSPD which in turn contracts with public and private providers for the delivery of services and

supports necessary to implement all programs funded partially or in-full with State monies. To assure the proper accounting for State funds, DSPD enters into a written State contract with each provider which includes a stipulation that claims for services provided be submitted to and paid by DSPD. This State-specific requirement applies regardless of whether: 1) the State funds are used for State-funds only programs or are used to draw down FFP as part of a 1915(c) HCBS Waiver program, or 2) the target population includes Medicaid-eligible citizens. The State contract is the sole responsibility of, and is managed by, DSPD's parent agency, the Department of Human Services.

In the case where a portion of the annual Legislative appropriation is designated for use as State matching funds for the Medicaid 1915(c) HCBS Waiver described herein, DSPD certifies to the State Medicaid Agency, through an interagency agreement, that the State funds will be transferred to the State Medicaid Agency in the amount necessary to reimburse the State match portion of actual Medicaid expenditures paid through the MMIS system for waiver services.

As a result of the State's organizational structure described above:

1. All providers participating in this 1915(c) HCBS Waiver must: a) fulfill the DSPD State contracting requirement as one of the waiver provider qualifications related to compliance with State law, and b) abide by the provision of the State contract to bill through DSPD for services provided.
2. The State Medicaid Agency reimburses DSPD for any interim payments that are made for legitimate waiver service claims during the time the clean claim is being processed through the MMIS system.
3. The State Medicaid Agency recovers from DSPD the State matching funds associated with the waiver expenditures.
4. The State Medicaid Agency approves all proposed rules, policies, and other documents related to the 1915(c) waiver prior to adoption by the DSPD policy board.

STATE MEDICAID AGENCY ROLE AND PROVIDER CONTRACT REQUIREMENT

The State Medicaid Agency, in fulfillment of its mandated authority and responsibilities related to the 1915(c) HCBS Waiver program, retains responsibility for negotiating a Medicaid Provider Agreement with each provider of waiver services. Unlike the DSPD State contract required of all providers of services to persons with disabilities who receive State monies, the Medicaid Provider Agreement is specific to providers of Medicaid funded services.

JOINT DSPD STATE CONTRACT/SMA PROVIDER AGREEMENT

The Personal Assistance provider category presents particular challenges to the effective and efficient operation of this Medicaid waiver. It is anticipated that this will be the sole instance in which individuals serving as Personal Assistants will be

associated with the Medicaid program as enrolled providers. It is also anticipated that the number of participating Personal Attendants will be significant, thus imposing a substantial administrative effort to negotiate required contracts and agreements. Therefore, for purposes of the effective management of the Personal Assistance (attendant) waiver service category only, a joint DSPD State Contract/SMA Provider Agreement has been developed. The joint state contract/provider agreement complies with the content requirements of Medicaid Provider Agreements and requires the signature of the service provider, DSPD, and the State Medicaid Agency. The effective date of the contract is the date the document is signed by all three parties.

DHS/DSPD requires submission of all mandatory State Audit requirements imposed on contracted providers by the State Auditor's Office. This information is a requirement of the contract entered into by DSPD and the provider.

Each year the DSPD Fiscal Review and Audit Unit reviews a sample of payment histories and the documentation to support those payments. This ensures the services were received and the correct payment was made. The sample includes information on all the contracted providers as well as recipient records.

Upon enrollment into the waiver the individual is informed of their responsibility and sign a letter of agreement to monitor and manage all employee(s) hours and wages. They are required to receive, sign and copy all employee(s) timesheets and submit them to the FMS agent twice a month. The participant is responsible to verify the accuracy of all hours billed by the employee(s).

Each month the administrative case manager reviews the billing statement and a monthly budget report generated by the DSPD Financial Analyst.

INTERAGENCY AGREEMENT FOR OPERATIONS AND ADMINISTRATION OF THE HCBS WAIVER

An interagency agreement between the State Medicaid Agency and DSPD sets forth the respective responsibilities for the administration and operation of this waiver. The agreement delineates the State Medicaid Agency's overall responsibility to provide management and oversight of the waiver including review and approval of all waiver related rules and policies to ensure compliance with Medicaid HCBS Waiver rules and regulations. The agreement also delineates DSPD's roles in relation to the statutory responsibilities to develop the State's program for persons with disabilities. The nature of the agreement enhances provider access to the Medicaid program and quality assurance of services as well as defines the fiscal relationship between the two agencies.

The major components of the agreement are:

1. Purpose and Scope;
2. Authority;
3. Definitions;
4. Waiver Program Administration and Operation Responsibilities;

5. Claims Processing;
6. Payment for Delegated Administrative Duties (including provisions for State match transfer);
7. Role Accountability and FFP Disallowances; and
8. Coordination of DHS Policy Development as it Relates to Implementation of the Medicaid Program.

APPENDIX I-2: Rates, Billing and Claims

a. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider invoices for payment flow directly to the State's claims payment system or whether invoices are routed through other intermediary entities. *If bills flow through other intermediary entities, specify the entities:*

Requests for payments from the contracted providers are submitted to the Dept of Human Services/DSPD on form 520; payments are then made to the providers. Dept of Human Services/DSPD submits billing claims to DOH for reimbursement.

For individuals self-directing their personal attendant(s), the participant submits their staff time sheet(s) to the FMS Agent. The FMS Agent pays the claim(s) and submits a bill to DHS/DSPD on form 520. DHS/DSPD pays the FMS Agent then submits billing claim to DOH for reimbursement.

b. Certifying Public Expenditures *(select one)*:

○	Governmental agencies directly expend funds for part or all of the cost of waiver services and certify the public expenditure (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):
☐	**Certified Public Expenditures (CPE) of a State Agency or Agencies**. Specify: (a) the agency or agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the expenditures that are certified are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue in section I-4-a.*)
☐	**Certified Public Expenditures (CPE) of a Local or other non-State Governmental Entity or Entities**. Specify: (a) the non-State governmental entity or entities that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue in section I-4-b.*)
✓	No governmental agencies directly expend funds for part or all of the cost of waiver services; there are no CPEs.

c. Billing Validation Process. Describe the process for validating invoices to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

DESCRIPTION OF BILLING PROCESS AND RECORDS RETENTION

1. A participant's Medicaid eligibility is determined by the Office of Health

and Eligibility within the Department of Workforce Services or the Bureau of Eligibility Services within the Department of Health. The information is entered into the Public Assistance Case Management Information System (PACMIS). PACMIS is an on-line, menu-driven system which automates Medicaid eligibility decisions, benefits amounts, participants' notices and administrative reports. PACMIS interfaces with other governmental agencies such as, Social Security, Employment Security, and the Internal Revenue Service. The system is a Federally-Approved Management Information System (FAMIS). In Utah, the following programs are accessed through PACMIS: Aid to Families with Dependent Children (AFDC), Medicaid, Food Stamps, and two state-administered programs - General Assistance and the Primary Care Network (PCN). The Medicaid Management Information System (MMIS) accesses PACMIS to ensure the participant is Medicaid eligible before payment of claims is made.

2. Post-payment reviews are conducted in accordance with the procedures outlined in Appendix E-2. The Medicaid agency reviews a sample of individual written support plans and Medicaid claims histories to ensure: (1) all of the services required by the individual are identified in the support plan, (2) that the individual is receiving the services identified in the support plan, and (3) that Medicaid reimbursement is not claimed for waiver services which were not included in the support plan.

2. Prior to the delivery of Medicaid reimbursed supported employment services, the Division of Rehabilitation Services (DRS) must document the individual's ineligibility for DRS services funded under section 110 of the Rehabilitation Act. The support coordinator will obtain written documentation (FORM 58) of the DRS determination prior to authorizing reimbursement for supported employment services under the waiver.

   Prior to the delivery of Medicaid reimbursed educational services, the waiver support coordinator must obtain written documentation that the services are not available to the individual through a program funded under section(s) (16) or (17) of the Individuals with Disabilities Education Act (IDEA) The support coordinator will obtain such documentation prior to authorizing Medicaid reimbursement for educational services under the waiver. (This requirement does not pertain to individuals over the age of 22 who are receiving educational services under the waiver.)

3. Prior to the order and delivery of Medicaid reimbursed approved specialized medical equipment, medical supplies, or assistive technology, the support coordinator must obtain prior approval based on a determination of medical necessity and a determination that the item is not available as a Medicaid State Plan service.

d. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

✓	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
○	Payments for some, but not all, waiver and State plan services are made through an approved MMIS. The process by which the State will maintain an audit trail for all State and Federal funds expended and under which payments are made outside the MMIS and by which payments will be made to providers is described below.
○	Payment for waiver services is not made through an approved MMIS. The process by which payments are made to the provider, how and through which system(s) the payments are processed, and the basis for the Federal draw of funds and claiming of expenditures on the CMS-64 are as follows:

b. Direct payment. As required by §1902(a)(32) of the Act, the State assures that payments are made by the Medicaid agency directly to the providers of waiver and State plan services. Payments for waiver services are made utilizing one or more of the following arrangements. (*check each that applies*):

✓	The Medicaid agency makes payments directly to providers of waiver services.
☐	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
☐	The Medicaid agency pays providers through the use of a limited fiscal agent that functions only to pay waiver claims. Specify the limited fiscal agent, the functions that the limited fiscal agent performs in paying waiver claims and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

c. Supplemental or Enhanced Payments.

Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. If supplemental or enhanced payments are made, provide the total amount for each type of supplemental or enhanced payment made to each provider type in the waiver. *Select one:*

✓	The State does not make supplemental or enhanced payments for waiver services.
○	The State makes supplemental or enhanced payments for waiver services. Specify below the total amount for each type of supplemental or enhanced payment that is made to each provider type in the waiver.

d. Payments to Public Providers. *Specify whether public providers receive payment for waiver services.*

✓	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services, the services that public providers furnish, and whether the amount of the payment to public providers differs from the amount paid to private providers of the same services: *Complete item I-3-e.*
	No differentiation is made in the waiver rate schedule for public providers. All providers are paid in accordance with the rate schedule.
○	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

✓	No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
○	When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:
○	When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State does not recoup the excess.

f. Provider Retention of Payments

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State Plan/waiver. *Select one:*

✓	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
○	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment process that results in other than 100% reimbursement of providers. Include the methodology for reduced or returned payments: a complete listing of providers, the amount or percentage of payments that are reduced or returned, and the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

○	Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
✓	The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

○	The State provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under this waiver; (e) how the State assures that OHCDS contracts with providers include applicable requirements; and, (f) how the State assures financial accountability when an OHCDS arrangement is used:
✓	The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with Organizations under the Provisions of §1915(a)(1) of the Act. *Select one:*

○	The State contracts with prepaid ambulatory health plan (PIHP) or prepaid inpatient health plan (PAHP) organizations under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive services through such organizations. Contracts with these organizations are on file at the State Medicaid agency. Describe: (a) the geographic areas served by these organizations; (b) the services furnished by these organizations; and, (c) how payments are made to organizations.
✓	The State does not contract with organizations for the delivery of waiver services under the provisions of §1915(a)(1) of the Act.

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

✓	**Appropriation of State tax revenues to the State Medicaid agency**
☐	**Appropriation of State tax revenues to a State agency other than the Medicaid agency.** If there are appropriations to another state agency, specify: (a) the entity or agency receiving appropriated funds; and, (b) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended as CPEs, as indicated in item I-2-b:
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended as CPEs, as indicated in I-2-b:

b. Local or other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from the state. *Check each that applies:*

☐	**Appropriation of local revenues.** Specify: (a) the local entity with authority to levy taxes or other revenues, (b) the source of revenue; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and /or, indicate if funds are directly expended as CPEs, as indicated in I-2-b-iii:
☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended as CPEs, as indicated in I-2-b-iii:
✓	**Not Applicable**. There are no non-State level sources of funds.

c. Information Concerning Certain Sources of Funds. Indicate whether any of the sources of funds listed in items (a) or (b) for the non-federal share of computable waiver costs come from the following sources. *Check each that applies.*

☐	Provider taxes
☐	Provider donations
☐	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:
✓	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

✓	No services under this waiver are furnished in residential settings other than the personal residence of the individual. (*Do not complete the remainder of this part*).
○	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete the next item*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.
Select one:

○	Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix J of this waiver request. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. The following is an explanation of: (a) the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse for these costs:
✓	The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. State Requirement for Co-pays. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. These are calculated per service and have the effect of reducing the total computable claim. *Select one:*

✓	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

Charges Associated with the Provision of Waiver Services *(if any are checked, complete item I-7-a-ii)*	
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge *(specify)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-6-b-iii and the groups for whom such charges are excluded. The groups of participants who are excluded must comply with 42 CFR §447.53.

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing as provided in 42 CFR §447.50. *Select one:*

✓	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee), the amount of charge and how the amount of the charge is related to total gross family income as set forth in 42 CFR §447.52; (b) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and (c) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver. If there is more than one level of care specified in the waiver, complete a separate additional table for each and include a table that reflects the weighted average of the combined levels of care offered in the program.

Level of Care (1) (specify):							
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D′	Total: D+D′	Factor G	Factor G′	Total: G+G′	Difference (Column 7 less Column 4)
1	$16,874.38	$16,972.05	$33,846.44	$25,148.70	$11,524.34	$36,673.04	$2,826.61
2	$17,211.87	$17,311.49	$34,523.36	$25,651.67	$11,754.83	$37,406.50	$2,883.14
3	$17,556.11	$17,657.72	$35,213.83	$26.164.70	$11,989.93	$38,154.63	$2,940.80
4	$17,907.23	$18,010.88	$35,918.11	$26,688.00	$12,229.73	$38,917.73	$2,999.62
5	$18,265.38	$18,371.09	$36,636.47	$27,221.76	$12,474.32	$39,696.08	$3,059.61

Level of Care (2) (specify):							
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D′	Total: D+D′	Factor G	Factor G′	Total: G+G′	Difference (Column 7 less Column 4)
1							
2							
3							
4							
5							

Weighted Average							
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D′	Total: D+D′	Factor G	Factor G′	Total: G+G′	Difference (Column 7 less Column 4)
1							
2							
3							
4							
5							

Appendix J-2 - Derivation of Estimates

a. Number Of Unduplicated Participants Served. As specified in Appendix B-2, the following table shows the maximum number of unduplicated participants who will be served each year that the waiver is in operation:

Table: J-2-a

Waiver Year	Unduplicated Number of Participants
Year 1	135
Year 2	135
Year 3	135
Year 4 (renewal only)	135
Year 5 (renewal only)	135

b. Phase-In/Phase-Out Schedule. Indicate whether the waiver is being phased-in or phased-out *(select one)*:

✓	The waiver is not subject to a phase-in or a phase-out schedule.
○	The waiver is being phased-in or phased-out. Attachment #1 to Appendix J-2 specifies the phase-in or phase-out schedule.

c. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-e.

Average Length of Stay (LOS) = 346 days
- Used the average annual LOS % increase for past 4 years (2002 – 2005) ~ 5.5%
- Multiplied the FY2005 actual LOS (328) by the average annual increase (5.5%)
- 328*1.055 = ~ 346 days

d. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-e. The basis for these estimates is as follows:

- All calculations are based off the actual amounts for FY2005
- Client Count for FY2005 was 112 and the new unduplicated# is 135 (an increase of ~ 21%), so all other Client Counts were raised by the same rate and rounded to the next whole number
- Financial Management Services client counts were calculated by allocating 80% to low level and 20% to high level
- Price per unit was increased 4% for the first year (to account for FY2006), and each subsequent year was increased 2%
- Units Per User is the average units per user for FY2005 rounded to the next whole number

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

- All calculations are based off the actual amounts for FY2005
- Average cost per enrollee was increased by 4% for the first year (to account for FY2006), and each subsequent year was increased 2%

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

- All calculations are based off the actual amounts for FY2005
- Average cost per enrollee was increased by 4% for the first year (to account for GY2006), and each subsequent year was increased 2%

iv. Factor G′ Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

- All calculations are based off the actual amounts for FY2005
- Average cost per enrollee was increased by 4% for the first year (to account for GY2006), and each subsequent year was increased 2%

e. Estimate of Factor D. Complete the following table for each waiver year

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Home Care Training to Client - Per 15 Min		13	5	$5.29	$343.54
Emergency Response System – Purchase		8	2	$26.01	$416.16
Emergency Response System – Per Month		61	11	$34.27	$22,995.69
Supports Brokerage, Self-Directed – Per 15 Min		99	32	$12.05	$38,167.53
Attendant Care Services – Per 15 Min		135	5929	$2.68	$2,148,499.56
Financial Management Services, Low – Per Month		108	12	$28.69	$37,182.24
Financial Management Services, High – Per Month		27	12	$93.94	$30,436.56
GRAND TOTAL:					$2,278,041.28
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					135
FACTOR D (Divide total by number of participants)					$16,874,38
AVERAGE LENGTH OF STAY ON THE WAIVER					346

Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Home Care Training to Client - Per 15 Min		13	5	$5.39	$350.41
Emergency Response System – Purchase		8	2	$26.53	$424.48
Emergency Response System – Per Month		61	11	$34.96	$23,455.60
Supports Brokerage, Self-Directed – Per 15 Min		99	32	$12.29	$38,930.88
Attendant Care Services – Per 15 Min		135	5929	$2.74	$2,191,469.55
Financial Management Services, Low – Per Month		108	12	$29.26	$37,925.88
Financial Management Services, High – Per Month		27	12	$95.82	$31,045.29
GRAND TOTAL:					$2,323,602.10
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					135
FACTOR D (Divide total by number of participants)					$17,211.87
AVERAGE LENGTH OF STAY ON THE WAIVER					346

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Home Care Training to Client - Per 15 Min		13	5	$5.50	$357.42
Emergency Response System – Purchase		8	2	$27.06	$432.97
Emergency Response System – Per Month		61	11	$35.66	$23,924.72
Supports Brokerage, Self-Directed – Per 15 Min		99	32	$12.53	$39,709.50
Attendant Care Services – Per 15 Min		135	5929	$2.79	$2,235,298.94
Financial Management Services, Low – Per Month		108	12	$29.85	$38.684.40
Financial Management Services, High – Per Month		27	12	$97.74	$31,666.20
GRAND TOTAL:					$2,370,074.15
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					135
FACTOR D (Divide total by number of participants)					$17,556.10
AVERAGE LENGTH OF STAY ON THE WAIVER					346

Waiver Year: Year 4 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Home Care Training to Client - Per 15 Min		13	5	$5.61	$364.57
Emergency Response System – Purchase		8	2	$27.60	$441.63
Emergency Response System – Per Month		61	11	$36.37	$24,403.21
Supports Brokerage, Self-Directed – Per 15 Min		99	32	$12.79	$40,503.69
Attendant Care Services – Per 15 Min		135	5929	$2.85	$2,280,004.92
Financial Management Services, Low – Per Month		108	12	$30.45	$39,458.09
Financial Management Services, High – Per Month		27	12	$99.69	$32,299.52
GRAND TOTAL:					$2,417,475.63
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					135
FACTOR D (Divide total by number of participants)					$17,907.23
AVERAGE LENGTH OF STAY ON THE WAIVER					346

Waiver Year: Year 5 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Home Care Training to Client - Per 15 Min		13	5	$5.72	$371.86
Emergency Response System – Purchase		8	2	$28.15	$450.46
Emergency Response System – Per Month		61	11	$37.10	$24,891.28
Supports Brokerage, Self-Directed – Per 15 Min		99	32	$13.04	$41,313.76
Attendant Care Services – Per 15 Min		135	5929	$2.91	$2,325,605.02
Financial Management Services, Low – Per Month		108	12	$31.05	$40,247.25
Financial Management Services, High – Per Month		27	12	$101.68	$32,945.51
GRAND TOTAL:					$2,465,825.14
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					135
FACTOR D (Divide total by number of participants)					$18,265.37
AVERAGE LENGTH OF STAY ON THE WAIVER					346